"COMPARING COGNITIVE FUNCTION, DEPRESSION, HOPE, AND QUALITY OF LIFE AMONG OLDER ADULTS: A STUDY OF HOME LIVING VS. RESIDENTS OF OLD AGE HOMES"

This dissertation is submitted in partial fulfilment for the degree of

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CERTIFICATE

This is to certify that the dissertation entitled "Comparing Cognitive Function, Depression, Hope, and Quality of Life Among Older Adults: A Study of Home Living vs. Residence of Old Age Homes" submitted by Miss Rupsa Raychaudhuri, a 4th semester master's student in applied psychology, (specialization in clinical psychology), Sister Nivedita University, is a Bonafide work, which may be placed before the board of examiners for final evaluation. This is in partial fulfilment of the degree of M.Sc. in applied psychology (specialization in clinical psychology), Sister Nivedita University.

This is an original study done by the candidate and has not been submitted by her before any form for any other degree of this university or any other university.

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PLAGIARISM DECLARATION

"I, Rupsa Raychaudhuri, hereby declare that the research work titled "Comparing Cognitive Function, Depression, Hope, and Quality of Life Among Older Adults: A Study of Home Living vs. Residence of Old Age Homes" conducted by me has been completed with full honesty and integrity. I confirm that the work is original, and all the sources of the information have been appropriately acknowledged and cited. Furthermore, I affirm that the research work has undergone thorough plagiarism checks to ensure its authenticity. I take full responsibility for the content and findings in this research."

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ABSTARCT

Introduction: Old age is a natural part of life, where people move into a new chapter filled with challenges and wisdom. As the body slows down and roles in family or society shift, many older adults face changes in health, independence, and social connection. Yet, this stage also brings a deep sense of experience, reflection, and resilience. Behind every wrinkle is a story, and behind every quiet moment, a lifetime of memories. While aging can bring feelings of loneliness or loss, it can also be a time of peace, growth, and meaningful connection with the right support and care. We must see, hear, and value our elders for all they continue to offer.

Objectives: To find out the relationship between the home-living elderly individuals and residents of an old-age home with respect to depression, quality of life, hope, and cognitive impairment.

Methodology: A comparative study was conducted among 100 participants (50 = home living individuals and 50= residents of an old age home), purposive sampling method was used. The Geriatric depression scale (GDS-15), the Quality-of-Life Scale (QOLS-16), the Trait Hope Scale, and Mini Mini-Mental Status Examination (MMSE) were administered to collect the data. For statistical analysis, Jamovi Software was used to perform the Shapiro-Wilk test for checking normality distribution, descriptive statistics were done (mean, median, mode, and standard deviation), and independent sample t-test was done to compare the difference between the two groups (home living elderly and residents of an old age home)

Results: The Level of depression, hope, and cognitive impairment is found to be higher among the individuals who are residents of an old-age home. There is a significant difference between the home-living elderly individuals and residents of old-age homes in respect to depression, hope, and cognitive impairments. But there is no significant difference between home-living elderly individuals and residents of an old age home in respect to quality of life.

Conclusion: Residents of an old age home face common mental difficulties like depression and cognitive impairments, and their level of hope is lower compared to home-living elderly individuals. This may be due to a lack of family interaction, a monotonous daily routine in old age homes, a lack of social interaction, and decision-making.

Key words: Old age, elderly people, residential home, Depression, Hope, Quality-of-life, Cognitive Impairments.

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Chapter 1

INTRODUCTION

INTRODUCTIONS

Aging is not an event but a process of growing older that includes a gradual in physical and mental abilities, which is a complex part of the life cycle. Aging, such a multi-dimensional process which effects every possible aspects of human life.

Gerontology is the study of aging and elderly individuals. The science of gerontology is growing because its longevity is also increasing. A more comprehensive definition of gerontology includes the following: scientific studies of processes associated with bodily changes from middle age to later life. Gerontogy is the study of aging. It is derived from the Greek words Geron (meaning "old man") and ology (a suffix meaning "the study of"). Gerontology is an interdisciplinary field. It is also a multidisciplinary field that entails the scientific study of physical, mental, and social changes in older people, investigating societal changes from an economic, historical, and philosophical standpoint, and implementing policies and procedures to assist older people based on gerontological information.

Geriatric psychology is the branch of psychology investigating older persons mental, emotional, and cognitive well-being. Individuals commonly experience distinct psychological issues as they age, including cognitive decline, dementia, depression, anxiety, grieving and adjusting to life transitions such as retirement and loss of independence. Geriatric psychologists diagnose and treat these through cognitive behavioural therapy (CBT), recollection therapy, and cognitive training. Therapists also help caregivers and families deal with the emotional and practical issues of aging. Furthermore, Gero psychologists encourage good aging by emphasizing resilience, social engagements, and coping methods to improve overall health. As the global population is growing, this field is also becoming increasingly important in improving the quality of life for elderly individuals as well as ensuring their dignity and mental health throughout the process of aging.

The mental health of the old-age population is an increasingly significant area of study in contemporary psychology, social sciences, and healthcare. As the global life expectancy rises due to advancements in medicine and healthcare infrastructure, the proportion of older adults within populations is also growing at an unprecedented rate. With this shift in the demographics, the mental health needs of the elderly have become a priority for researchers, policymakers, and clinicians. Aging is a complex process which involves physical, cognitive and emotional changes impacting overall well-being. The psychological well-being of elderly people is shaped by several factors, such as, social support, physical health, economic stability,

and personal resilience. There are some common mental health challenges in this population, including depression, anxiety, dementia, and social isolation, that necessitate a multidisciplinary approach to understand and address these concerns. Moreover, elderly individuals often experience grief, chronic stress, and existential concerns, which further complicate their mental health scenario.

Mental health issues in the old age people are often left undiagnosed or untreated due to stigma, lack of awareness, or insufficient healthcare resources. There are many older adults who hesitate to seek psychological support out of fear of being perceived as weak or incapable. In addition, mental health symptoms in geriatric individuals are differently manifested in younger populations. For instance, depression in older adults may present more as fatigue, sleep disturbances, or cognitive impairment rather than overt sadness. These symptoms are frequently misattributed to normal aging or physical illnesses, which leads to underdiagnosis and inadequate treatment.

Furthermore, social isolation is considered to be a major contributor to mental health decline in the elderly. The loss of a spouse, relationship with children, retirement, mobility restrictions, and reduced social networks can contribute to loneliness, which is strongly associated with depression and cognitive decline. Additionally, chronic illnesses like diabetes, hypertension, and arthritis cam also exacerbate mental health issues, which makes it crucial to adopt a holistic approach in managing geriatric well-being.

One of the foundational frameworks for understanding the psychological development of older adults is Erik Erikson’s psychosocial development theory, that explains eight stages of human growth. Out of which the last two stages, generativity vs. stagnation and integrity vs. despair, are particularly relevant to geriatric mental health. During the generativity vs. stagnation stage, occurring in middle adulthood, individuals may focus on contributing to society through work, family, and community involvement. If this stage achieve success, then that leads to a sense of fulfilment and productivity; and if not, they may experience stagnation and a sense of purposelessness. In gerontology, "stagnation" refers to a psychological state where an older adult feels stuck, unproductive, and lacks a sense of purpose in life, which often leading to negative impacts on their mental health, social connections, and overall well-being as they age, including potential declines in cognitive function, poorer health outcomes, and decreased life satisfaction.

The syntonic quality of adulthood is generativity, which is defined as the generation if new beings, products and ideas. It is mainly concerned with guiding the next generation which includes the production of works, procreation of children and the creation of new things and ideas that contribute to build a better world. It also involves caring for others, mentoring, creating and making meaningful contributions to family, work and the broader community, and reflects a sense of purpose and fulfilment. The antithesis of generativity is stagnation and self-absorption. The generational cycle of creativity and productivity is hampered when people become too absorbed and too indulgent in themselves. Pervading sense of stagnation fostered by such attitudes. Some elements of stagnation and self-absorption are necessary.

The main virtue of this stage, generativity vs stagnation is care, which is the basic strength of adulthood. Erik Erikson defined care as a widening commitment to take care of the persons, the products, and the ideas one has learned to care for. As the basic strength of adulthood, care arises from each earlier basic ego strength. One must have hope, will, purpose, confidence, fidelity, and love to take care of that which one cares for. Care is not just a duty or obligation but also a natural desire that emerges from a conflict between generativity and stagnation or self-absorption. The antipathy of care is objectivity. Objectivity is defined as the unwillingness to take care of the person or groups. It is also manifested by self-centredness, provincialism, and pseudo-speciation, which is the belief that other groups of people are inferior to one's own.

Old age marks the final stage of life's journey, typically beginning around 60 years old and lasting until the end of life. Erik Erikson originally defined this stage in his early 40s, recognizing that aging does not mean losing purpose or creativity. Even if older adults are no longer raising children, they can still be productive, caring, and deeply involved in the lives of others. Many find joy in mentoring younger generations, guiding their grandchildren, or contributing to their communities in meaningful ways. This stage can be a time of joy, playfulness, and deep wisdom, but it can also bring challenges like loneliness, regret, or health struggles. The key challenge is balancing integrity versus despair, finding peace in one's life story rather than dwelling on missed opportunities. When individuals embrace their experiences with gratitude and wisdom, they can approach aging with fulfilment and a sense of purpose rather than fear or sadness. Old age is not just an ending rather it can be a time of reflection, connection, and even newfound creativity.

As people age, evolutions of pleasure and intimacy in their relationships are often noticed. Erikson described generalized sensuality as a learning stage where individuals find joy in a

variety of physical sensations such as the warmth of sunlight, the sound of laughter, the taste of a favourite meal, a comforting embrace, or even deep emotional connections. At this stage, many people start developing a greater appreciation for life that is beyond traditional roles, where men may become more nurturing and place greater value on nonsexual relationships, especially with their grandchildren and younger generations. Women, in turn, may explore new interests in politics, finance, or leadership roles, in which they might not have focused on earlier in their lives. However, maintaining this attitude of openness and enjoyment depends on one's ability to stay connected and to hold onto a sense of identity and purpose, even in the face of aging and loss. Those who accept this stage with curiosity and acceptance can experience a deep and fulfilling connection towards the world around them by finding beauty in everyday life moments.

The final stage of Erik Erikson's psychosocial stage is about finding peace or regretting about past. When people reach the final stage of life, they often look back and reflect on their journey, that is, the choices they made, the relationships, and the legacy they left behind. This stage, called integrity versus despair, determines whether the individuals approach the end of life with peace and fulfilment or with regret and sorrow. For those who have lived with purpose, connection, and love, a deep sense of integrity emerges, which makes them feel a sense of wholeness, i.e., the "I-ness," knowing they have contributed to the world in meaningful ways. Even as their physical and mental abilities decline, they can still find wisdom, contentment, and acceptance in their overall life experiences.

However, for those individuals who feel that they have wasted opportunities in their life or failed to create meaningful relationships, despair may take place. They may struggle with regrets, loneliness, and a sense of unfinished business, which makes it difficult for them to find peace in their final years. Ultimately, this stage is about reconciliation, coming to terms with one's past, embracing life's lessons, and finding comfort in the moments that remain. Those individuals who accept both their successes and failures can face the end of life with dignity, wisdom, and a sense of completion. As people grow older, it can be difficult to maintain a strong sense of self when so many familiar aspects of life begin to change or fade away. Losing a spouse, close friends, physical health, independence, or mental sharpness can create a deep sense of loss. These changes may lead to feelings of helplessness, frustration, or even a fear of becoming irrelevant.

When faced with these struggles, some individuals may experience sadness, resentment, or withdrawal from others, and they might feel disconnected from the world around them where they are unable to accept the natural limits of life. Moreover, those who learn to embrace change with grace and adaptability can find meaning even in the challenges of aging.

By focusing on the love, memories, and wisdom they have gained, older adults can shift their perspective from one of loss to one of appreciation. Rather than dwelling on what has gone, they can celebrate the life they have lived and the people they have touched. Despair means to be without hope; the last dystonic quality of the life cycle is in the opposite corner from hope, the person's basic strength. Once hope is lost, despair follows, and life ceases its meaning. As people grow older, they inevitably face a struggle between integrity and despair, a battle between accepting life as it is or regretting about the paths they had not taken. Out of this struggle comes wisdom, the defining strength of old age. Erik Erikson described wisdom as "an informed and detached concern with life itself in the face of death itself." In other words, it is the ability to look at life with understanding, acceptance, and a sense of perspective.

True wisdom doesn't mean indifference or a lack of care. Instead, it reflects an active yet balanced interest in life. Those individuals who develop wisdom can hold on to their sense of identity and self-worth, even if their physical strength and mental health decline. They find meaning in the lessons they've learned and pass that knowledge down to younger generations, which contributes to a cycle of shared human experience.

On the other hand, the opposite of wisdom is disdain, which refers to a feeling of frustration, helplessness, or even bitterness toward oneself and others. Erikson described disdain as the emotional response to seeing one's limitations and the limitations of others around them. It stems from an inability to accept the natural process of aging, leading to feelings of resentment, confusion, and even withdrawal from life. In his later years, Erikson himself became less optimistic about aging. Together with his wife, Joan, he explored the idea of a ninth stage of life, a period of extreme old age when the loss of physical and mental abilities can make people feel as though they are merely waiting for the end. Despite these challenges, wisdom remains a powerful force in aging. It allows people to face the realities of life with dignity, embrace their experiences, both good and bad, and find peace in the knowledge that their journey has had purpose.

Depression becomes a very common factors when people age. Depression is defined as an emotional state characterized by extraordinary sadness and dejection. It is a period of markedly

depressed mood or loss of interest in formerly pleasurable activities or both for at least 2 weeks, accompanied by other symptoms such as changes in sleep or appetite or feelings of worthlessness.

There are several characteristics of depression according to DSM-5-TR

- Depressed mood most of the day, nearly every day.
- Markedly diminished interest in activities or pleasure.
- Significant weight loss or weight gain.
- Insomnia or hypersomnia.
- Psychomotor agitation or retardation nearly every day.
- Fatigue or loss of energy.
- Feelings of worthlessness or excessive or inappropriate guilt.
- Diminished ability to think and concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

Beck's Cognitive Theory of Depression is one of the most influential psychological models explaining the development and maintenance of depression. The theory suggests that depression is primarily caused by persistent negative thought patterns rather than external life events alone. According to Beck, individuals with depression tend to interpret their experiences in a biased and distorted manner leading to a cycle of negative thinking that increase the symptoms. At the core of this theory is the Negative Cognitive Triad, which consists of three interrelated components. Those are a negative view of the self, a negative view of the world, and a negative view of the future. Individuals who are depressed often see themselves as inadequate, flawed, or unworthy. They perceive the world as an unfair, hostile, or overwhelming place. Additionally, they hold a pessimistic outlook about the future, believing that their situation is hopeless and improvement is impossible. These recurring patterns of negative thoughts create a self-reinforcing cycle that further deepens the feelings of sadness, hopelessness, and helplessness.

A key component of Beck's theory is the presence of cognitive distortions, which are irrational, exaggerated, and self-defeating ways of thinking that contribute to depression. These cognitive distortions act as filters that distort reality, causing individuals to misinterpret experiences in a way that confirms their negative beliefs. Some of the most common distortions include all-or-none thinking (which is seeing things in extreme, black-or-white terms), catastrophizing

(expecting the worst possible outcome in every situation), overgeneralization (negative conclusions from a single event), mind reading (assuming others have negative thoughts about you without evidence), and discounting the positive (ignoring or dismissing positive feedback or accomplishments. These distorted thinking patterns become automatic over time, meaning that individuals engage unconsciously and reinforce their depressive state.

Another crucial element of Beck's cognitive model is the concept of schemas or core beliefs. Schemas are deep-seated cognitive structures that develop in early life based on experiences, especially those involving caregivers, peers, or significant life events. If a child grows up in an environment where they are frequently criticized, ignored, or neglected, they may develop negative schemas such as "they are unlovable," "they are worthless," or "they are destined to fail." Once formed, these schemas act as filters through which individuals interpret reality, meaning that they tend to focus on negative aspects of situations while ignoring positive evidence. For example, a person with a schema of unworthiness might receive praise for their work but still believe that they are inadequate, attributing their success to luck rather than their abilities. These schemas remain dormant until they are activated by stressful life events, such as job loss, rejection, or failure, at which point they trigger a cascade of negative thoughts that contribute to depression.

The development of depression, according to Beck, follows a specific pattern. First, early experiences (such as negative childhood events) lead to the formation of maladaptive schemas. These schemas remain latent but can be activated by stressors in adulthood. Once activated, they generate automatic negative thoughts, which lead to cognitive distortions and reinforce the Negative Cognitive Triad. As negative thinking patterns become more frequent, they result in emotional symptoms (such as sadness, guilt, and hopelessness), behavioural symptoms (like social withdrawal and lack of motivation), and physiological symptoms (such as fatigue and changes in appetite or sleep). This cycle perpetuates depression and makes it difficult for individuals to break free from their negative thinking patterns.

Beck's cognitive model of depression laid the foundation for Cognitive Therapy, now known as Cognitive Behavioural Therapy (CBT), one of the most effective and widely used treatments for depression. CBT is based on the idea that if individuals can learn to recognize and change their negative thought patterns, they can improve their mood and overall functioning. The therapy focuses on several key techniques, including cognitive restructuring (identifying and challenging irrational thoughts), behavioural activation (encouraging individuals to engage in

enjoyable activities to improve mood), and reality testing (examining evidence for and against negative beliefs to develop a more balanced perspective). For example, if a person believes they are a failure, a therapist might ask them to list past achievements to counter that belief. Over time, CBT helps individuals develop healthier thought patterns and reduce depressive symptoms.

Despite its strong empirical support, Beck's cognitive theory has faced some criticisms. One major critique is the causality issue—while research confirms that negative thinking is associated with depression, it is unclear whether depression is caused by negative thoughts or if depression causes negative thoughts. Additionally, some argue that the theory underemphasizes biological factors, such as genetic predisposition and neurochemical imbalances, which also play a significant role in depression. Moreover, the theory does not fully account for sociocultural factors, such as poverty, discrimination, and trauma, which can contribute to depression beyond cognitive distortions. Nonetheless, the Cognitive Theory of Depression remains one of the most influential models in psychology, and its principles continue to guide modern therapeutic interventions. Its emphasis on modifying thought patterns has led to effective, evidence-based treatments that have helped countless individuals recover from depression.

Hope is defined as a feeling of positivity and the possibility of something good occurring. It is the expectation of improvement even during hard times. Hope generally stems from faith, experience, or simply a wish for a favourable result.

Snyder's hopeful people theory outlines hope as an emotion accompanied by an active cognitive process rather than a passive experience. Snyder argues hope is dependent on two 'building blocks' called 'pathway thinking' and 'agency thinking' that permit individuals to set, attempt, and accomplish goals even when there are problems.

Pathway Thinking

Pathway thinking is the ability of a person to conceive several different ways of accomplishing a given task or a goal. The people endowed with strong pathway thinking are the ones who do not look at barriers as obstacles. A good example would be a student who wants to pass a challenging course exam, but his/her current method of studying for the exam is not working. Instead of sticking to the same method of study, the student can try other methods such as flashcards, forming a study group, or getting help from a tutor. The ability to actively devise

alternate routes to achieve their goal gives these individuals the upper hand and does not restrict them from making attempts when needed.

Agency thinking

Agency thinking is hope's motivational component, which represents a person's capability to self-hope regardless of the obstacles. It is the vital force that propels an individual towards goal achievement. A person might have agency thinking but have no competence or determination to pursue it. Using the same case as before, a student can overcome fatigue and self-doubt, but only if they retain motivation throughout the challenges.

The Role of Hope in Daily Life

As a result, hope can be a powerful motivator, since it protects resilience, problem-solving skills, and positive emotions. High-hope individuals look forward into the future with optimism and action, while those with lower hope feel stagnant or hopeless. As a result, academic achievement, career progression, mental or physical health, and even personal relationships are all impacted by a hopeful person. For example, a hopeful entrepreneur will come up with several ways the business can grow (pathway thinking) and remain motivated to achieve those goals regardless of the challenges in the market (agency thinking). In the same spirit, a patient recovering from an illness can believe and therefore benefit from various treatment options.

Snyder’s theory of hope has been implemented widely in positive psychology, education, healthcare, and even therapy. In learning environments, creating hope among learners has beneficial effects on academic performance, motivation, and problem-solving. In medicine, patients hoping for a recovery usually do better. Such patients tend to comply with treatment regimens more and are generally more positive. In therapy, fostering pathways and agency thinking or helping helps build resilience and allows clients to take charge of their lives.

In summary, Snyder's Hope Theory has made it clear that hope is more than mere wishing – it involves active and deliberate thought processes that push individuals toward achieving success. People can develop optimism, motivation, and personal growth by practicing agency thinking, which allows one to take action, and pathway thinking, which helps find ways forward. This way, hope can be transformed from a passive feeling all humans possess into an invaluable psychological capacity that needs to be cultivated over time.

Hope is crucial for the well-being of older adults, impacting their physical health, emotional strength, and overall quality of life. As individuals age, they encounter various challenges,

including declining health, the loss of loved ones, social isolation, and diminished independence. The ability to maintain or lose hope can significantly influence how they navigate these difficulties.

A strong sense of hope in older adults can lead to several advantages. Those are-

Better Physical Health: Those who are hopeful often engage in healthier habits, such as following medical advice, staying active, and eating well. Their optimistic outlook helps lower stress levels, which can boost the immune system and decrease the likelihood of chronic diseases.

Emotional Resilience: Hope enables older adults to adjust to life changes, like retirement, physical limitations, or bereavement. It helps them discover new purposes in life, whether through hobbies, volunteering, or spending time with family.

Stronger Social Connections: Hope motivates individuals to stay socially engaged, seek companionship, and cultivate meaningful relationships. Social support is vital for mental health and can help ward off loneliness and depression.

Increased Sense of Purpose: Older adults filled with hope often set new goals and participate in activities that bring them joy, such as learning new skills, mentoring younger people, or exploring creative interests. Having a sense of purpose is associated with greater longevity.

Better Mental Health: Hope can lower the risk of depression and anxiety by promoting a positive view of the future. It allows older individuals to concentrate on what they can still enjoy rather than fixating on their losses.

Although lack of hope also has some negative impacts. Those are -

False Hope: Some older individuals may have unrealistic expectations regarding their health or future, which can lead to disappointment. For instance, hoping for a complete recovery from a chronic illness without acknowledging medical limitations can result in distress when reality falls short of those expectations.

Avoidance of Reality: Excessive hope can sometimes lead to denial, where an older adult refuses to recognize their limitations or seek the help they need. For example, someone who wishes to live independently but struggles with mobility might resist moving to assisted living, putting themselves in a precarious situation.

Dependency on External Factors: When hope relies solely on external circumstances (like financial stability or family support), losing those factors can lead to feelings of despair. A healthy sense of hope should incorporate internal coping strategies rather than depending entirely on outside sources. What Happens When Older Adults Lack Hope? A lack of hope in later life can have serious physical, emotional, and psychological effects:

Increased Risk of Depression and Anxiety: Hopelessness is closely linked to depression, a prevalent mental health issue among older adults. Feelings of purposelessness, loneliness, and despair can lead to withdrawal from social interactions and a decline in overall well-being.

Decline in Physical Health: Studies indicate that hopelessness correlates with higher stress levels, inflammation, and a weakened immune system. Individuals who feel hopeless may neglect their health, miss medical appointments, or improperly manage their medications.

Loss of Motivation and Purpose: Older adults who lack hope often disengage from meaningful activities, which can contribute to cognitive decline and a diminished sense of self-worth. A lack of participation in social or intellectual pursuits may hasten the onset of dementia and other cognitive impairments, it can sometimes lead to negative outcomes if it is not based in reality.

Social Isolation: Feelings of hopelessness can lead older adults to distance themselves from family and friends, resulting in loneliness and increased emotional turmoil. This isolation can create a vicious cycle that negatively impacts both mental and physical health.

Increased Risk of Suicide: In severe situations, a deep sense of hopelessness may trigger suicidal thoughts, especially among elderly individuals who perceive themselves as lacking purpose, support, or as a burden to others.

Hope serves as a vital psychological resource for older adults, shaping their health, resilience, and overall quality of life. While realistic hope can nurture optimism, motivation, and a sense of purpose, the absence of hope or unrealistic expectations can result in disappointment, denial, or despair. Promoting hope through social connections, setting achievable goals, therapy, and community involvement can greatly enhance the well-being of older individuals.

Quality of life is defined as the individual's perception of their positions in life in the context of culture and another value system. The Quality-of-Life Scale (QOLS), which Carral S. Burckhardt created, serves as a trusted method to evaluate a person's overall life quality. It helps to grasp how individuals see their well-being in various life areas taking into account

both their personal feelings and concrete factors that add to life satisfaction. This scale builds on the concept that life quality is a multifaceted idea that one can't understand by looking at just one aspect such as physical health. This led Burckhardt to design the QOLS to assess several key areas that play a vital role in a person's overall life experience.

The QOLS looks at several areas:

Physical Well-being: This area looks at a person's physical health considering things like how well they can do everyday tasks, whether they're in pain, and how their body works overall. It also checks how health issues or treatments might affect someone's physical condition. Understanding physical well-being is key to exploring how health and overall life satisfaction are linked to people with long-term illnesses or disabilities.

Social Relationships: Connections with others play a key role in how good our lives are. This area looks at how well we get along with people, including family, friends, and folks in our community. It checks if we feel supported by others how often we interact with people, and how happy we are with our social life overall. The bonds we form with others have a big impact on our mental health and can shape how content we feel.

Environmental Factors: This area examines the outside conditions where a person resides, including housing, safety, healthcare access, transportation, and overall living environment. It takes into account both the physical aspects of the surroundings (like enough living space financial stability, and resource availability) and the social setting (such as the existence of supportive community networks). The environmental realm plays a key role to understand how one's surroundings have an impact on their quality of life regarding access to vital services and the sense of safety and security.

Independence: This area looks at how well a person can stay self-reliant and in charge of their life. It covers things like being able to choose for yourself, handle day-to-day tasks without leaning too much on others, and keep a feeling of being in control. Being independent is key for older folks or those with disabilities, as it has an impact on how they see their own worth and dignity.

Burckhardt's QOLS seeks to offer a complete picture of a person's life, recognizing that various life areas are linked and all contribute to someone's overall contentment and wellness. The scale usually has a set of questions to gauge satisfaction in each of these areas. People rate how happy they are with different parts of their lives, giving a personal measure of their life quality.

This tool proves useful in both medical settings and studies, helping doctors and social researchers to better grasp the ins and outs of human wellness and how it affects health results when dealing with long-term illnesses, mental health issues, and older folks.

The QOLS is utilized in various sectors, such as healthcare, social services, and public health research. It provides professionals with a way to observe changes in quality of life over time, recognize areas needing enhancement, and evaluate the success of interventions. Its extensive focus on multiple aspects of life makes it a versatile resource for assessing the quality of life in individuals from a variety of backgrounds and health situations. This tool ultimately helps clinicians and researchers gain insight into how different factors—both internal, like emotional well-being, and external, such as environmental conditions and impact a person's overall view of their life. Quality of Life (QoL) and Maslow's Hierarchy of Needs are interconnected concepts that both emphasize human well-being and fulfilment. Maslow's theory, depicted as a pyramid of human needs, offers a framework for understanding the elements that contribute to a high quality of life. Here's how QoL relates to each level of Maslow's hierarchy:

1. *Physiological Needs (Basic Survival)*

These encompass essentials like food, water, shelter, sleep, and health. A person's quality of life is significantly impacted when these fundamental needs are not met. Issues such as poor nutrition, lack of clean water, inadequate housing, and insufficient healthcare can severely diminish QoL.

2. *Safety Needs (Security & Stability)*

These involve personal security, financial stability, health security, and protection from harm. Having a stable job, access to healthcare, and a safe living environment enhances QoL. Conversely, factors like war, crime, and economic instability can lower it.

3. *Love & Belonging (Social Relationships)*

These include friendships, family ties, romantic relationships, and a sense of community. Strong social connections and emotional support can greatly enhance QoL, while feelings of loneliness and social isolation can detract from it.

4. *Esteem Needs (Self-Worth & Recognition)*

These consist of respect, achievement, confidence, and recognition from society. Feeling valued and having a sense of self-esteem can improve mental well-being and life satisfaction, which directly influences quality of life.

5. *Self-Actualization (Personal Growth & Fulfilment)*

This level includes creativity and the pursuit of personal passions. Achieving self-actualization leads to a deeper sense of purpose, contributing to a more fulfilling life. There are a few ways through which quality of life and Maslow's hierarchy theory are connected. They are,

Stepwise Improvement – A person's quality of life (QoL) tends to improve as they ascend through Maslow's hierarchy.

Holistic Perspective – QoL encompasses more than just material wealth (such as money and safety); it also includes emotional, social, and psychological satisfaction.

Maslow's hierarchy offers a clear framework for understanding the various factors that contribute to quality of life. The more effectively an individual's needs are satisfied at each level, the greater their overall quality of life.

Cognition refers to the mental processes involved in acquiring, processing, storing, and using information. It encompasses various activities such as perception, attention, memory, problem-solving, decision-making, and language comprehension. Cognition allows individuals to interpret and respond to their environment, learn from experiences, and adapt to new situations. These cognitive processes are essential for everyday functioning and are influenced by both internal and external factors, including genetics, emotions, education, and social interactions. Furthermore, cognition plays a crucial role in shaping behaviour, guiding thoughts, and helping individuals navigate complex situations by making sense of the world around them.

Cognitive psychology, a branch of psychology, focuses on how people think, learn, and remember. It examines the internal mental processes that influence human behaviour and seeks to understand how information is processed in the brain. Cognitive psychologists investigate topics such as attention, memory, problem-solving, language development, and decision-making. This field emerged as a reaction to behaviourism, which primarily focused on observable behaviours rather than internal mental states. Cognitive psychology has applications in various areas, including education, artificial intelligence, therapy, and

neuroscience. By understanding cognitive functions, researchers and practitioners can develop strategies to enhance learning, improve memory retention, and address cognitive disorders such as dementia and attention-deficit disorders.

Several factors influence cognition, including genetics, environment, health, and emotions. Age is one of the most significant factors affecting cognition. As individuals grow older, their cognitive abilities may decline due to structural and functional changes in the brain. For instance, working memory and processing speed tend to decrease with age, while crystallized intelligence, which involves accumulated knowledge and experience, generally remains stable. Neurobiological changes, such as decreased synaptic plasticity, reduced neurotransmitter levels, and the shrinkage of regions like the hippocampus, contribute to cognitive decline. However, engaging in mental stimulation, physical exercise, social interactions, and maintaining a healthy lifestyle can help slow cognitive deterioration and promote cognitive resilience in aging individuals.

Beck's Cognitive Triad Theory is a fundamental model in cognitive psychology that explains the negative thought patterns contributing to depression. Developed by psychiatrist Aaron Beck, this theory suggests that depression arises from a cycle of persistent negative thinking centred around three interconnected cognitive distortions: a negative view of the self, the world, and the future. Individuals experiencing depression often perceive themselves as inadequate, unworthy, or failures, which reinforces low self-esteem. Their negative view of the world leads them to see their surroundings as hostile, unfair, or overwhelming, resulting in feelings of helplessness. Additionally, their negative outlook on the future causes them to expect failure, rejection, or ongoing suffering, fostering a sense of hopelessness.

These distorted perceptions are further reinforced by cognitive biases, such as overgeneralization (believing that a single failure applies to all situations), catastrophizing (expecting the worst possible outcome), and selective abstraction (focusing solely on negative aspects while ignoring positive ones). Beck argued that these maladaptive thought patterns are not just symptoms of depression but fundamental causes that perpetuate the disorder.

His work led to the development of cognitive-behavioural therapy (CBT), which focuses on identifying and restructuring these irrational beliefs. CBT helps individuals challenge their negative thoughts, replace them with more balanced perspectives, and develop coping strategies to improve emotional well-being. Beck’s theory has had a lasting impact on clinical psychology, influencing the treatment of mood disorders, anxiety, and other mental health

conditions by emphasizing the role of cognition in emotional regulation and behaviour modification.

The factors like depression, hope and cognitive impairment is highly crucial for old age people, this study aims to find out whether there is any relationship between depression, quality of life, hope and cognitive impairment among old age people who is living at their home and those who are staying at the old age residences.

Depression, cognitive impairment, level of hope, and quality of life are very crucial for elderly individuals to assess as they approach the verge of the end of life. Aging is a normal phenomenon that every individual goes into. There are several other studies on elderly individuals and their mental health.

Chapter 2

LITERATURE REVIEW

LITERATURE REVIEW

Literature review is the collective body of work done by earlier scientists. Any scientific investigation starts with a review of the literature. Reviewing literature helps generate new ideas, helps in developing significant questions, and is regarded as the instrumental process of research design. The main objectives of reviewing of literature are identifying variables related to research, avoiding repetition, synthesizing prior works, and determining the meaning and relationship among variables. There are some general purposes of literature review, which are to argue for the relevance and the significance of the research questions, to provide the context for one's methodological approach, to establish one's credibility as a knowledgeable and capable researcher, and to argue for the relevance and appropriateness of one's approach.

Geriatric populations and mental health:

In the research titled "Geriatric mental health: An overview", the well-being of older individuals is a significant social and health priority in the US. The mental health of the rapidly growing older adult population is very important. Older persons frequently receive insufficient or incorrect mental health services. The intricacy of determining the differential diagnosis of health problems in elders makes it difficult to provide appropriate, effective care. Mental health providers must understand not just the distinctive presentation of psychiatric problems in older persons, but also normal ageing, diseases and disabilities of ageing, and the cultural variation seen between and among subgroups. The focus of this article will be on geriatric mental health, including concerns and barriers that have impacted the diagnosis and treatment of mental health problems and psychiatric disorders in older persons. Areas of concern raised in recent Surgeon General reports on older adult suicide and mental health will be discussed. A case scenario will be presented to highlight major concerns in geriatric mental health care. (Morris et al., 2001).

In the research titled "Geriatric mental health services research: strategic plan for an aging population: report of the Health Services Work Group of the American Association for Geriatric Psychiatry", in 1999, the American Association for Geriatric Psychiatry (AAGP) formed a working group to make strategic suggestions for expanding geriatric mental health care research as a scientific discipline. The resulting consensus statement summarises the principles that guide mental health services research on late-life mental disorders, identifies timely and topical research priorities that have the potential to improve the lives of older adults and their families, and outlines a systematic program for increasing the supply of well-trained geriatric mental health services researchers. The agenda offered here is intended to address crucial

problems about the provision of appropriate mental health care to an ageing population, as well as the health policies that regulate its delivery. (Borson et al. 2001).

In the research tilted “Evidence-based practices in geriatric mental health care” it is found that, over the past decade, there has been a significant increase in research on treating psychiatric disorders in older persons. An expanding body of research supports the usefulness of geriatric mental health therapies. The authors give an overview of the evidence base for clinical practice. They identified three types of evidence: evidence-based reviews, meta-analyses, and expert consensus statements on established and emerging therapies for the most common late-life diseases, such as depression, dementia, substance addiction, schizophrenia, and anxiety. The efficacy of pharmaceutical and psychosocial therapies for geriatric major depression and dementia has received the most scientific attention. Treatments for other illnesses are less well understood, while accumulating evidence suggests that certain approaches may be useful. Empirical evidence also supports the usefulness of community-based, interdisciplinary geriatric psychiatric treatment teams. The authors explore the challenges to integrating evidence-based approaches in the mental health service delivery system for older individuals. They provide strategies for addressing these hurdles based on research findings on practice change and dissemination. Successful approaches to implementing change in provider practices emphasise expanding beyond traditional models of continuing medical education to include educational techniques that actively engage the learner, as well as system change interventions such as integrated care management, implementation toolkits, automated reminders, and decision support technologies. The predicted increase in the population of older people with mental illnesses highlights the need for a strategy to assist the systematic and successful application of evidence-based methods in geriatric mental health treatment. (Bartels et al, 2002).

In the research titled “Evidence-based practices in geriatric mental health care: an overview of systematic reviews and meta-analyses”, Approximately one in every five adults over 65 experience mental health issues. Over the next 30 years, the number of older Americans with psychiatric problems is expected to double, bringing it to equal the number of younger Americans (ages 30 to 44). Despite the increased demand for mental health treatments for older people, there is a significant unmet need. The latest Surgeon General's Report on Mental Health, the Administration on Aging's Report on Mental Health, and an expert consensus statement all emphasise the importance of preparing for the task of providing care to the growing number of elderly people with significant mental illnesses. One of the most difficult

issues for doctors working in everyday clinical settings is a lack of competence. This gap is due to insufficient geriatrics training and a failure to incorporate current clinical research findings and known evidence-based practices (EBPs) into standard care. This article summarises the emerging evidence base supporting the efficacy of empirically validated geriatric mental health interventions for major geriatric mental health disorders, which includes systematic EBP reviews, meta-analytic studies, and expert consensus statements. Cautions and limitations regarding the reliance on randomized, controlled trials (RCTs), meta-analyses, and systematic reviews also are presented. (Bartels et al, 2003).

In the research titled “State of geriatric mental health in India”, India's senior population is steadily expanding. Depression, dementia, and anxiety disorders are the most common psychiatric ailments among India's senior population. The resources available to meet the needs of the elderly in the country include government and private psychiatric institutions, non-governmental organisations, and family carers. The obstacles that confront the future of geriatric psychiatry in India include a lack of awareness, insufficient training opportunities, an unequal allocation of health resources, and the virtual absence of chronic care illness models. Government initiatives offering social benefits to the senior population exist, however coverage is low. To address senior mental health challenges, it is critical to raise awareness, improve capacity, strengthen training and research efforts, implement community-based rehabilitation programmes, and establish a comprehensive primary health care system. (Prakash et al. 2013).

In the research titled “Geriatric mental health: The challenges for India” is it found that the geriatric mental health is not fully recognised in India. Geriatric mental health faces numerous problems that impede the development and advancement of its services. The current article is a narrative review that examines the different difficulties confronting senior mental health in India. The article outlines the several special and general unique obstacles that geriatric mental health faces, as well as the nature of each challenge and what has to be done to overcome them. The concerns span from the demographics of Indian ageing to sexual issues among the aged, geriatric depression, dementia care, and the ageing lesbian, gay, bisexual, and transgender society. A variety of policy and research problems affecting geriatric mental health are also explored. The importance of incorporating geriatric mental health into primary health care, as well as training primary care personnel and implementing preventive measures to prevent suicide in the elderly, is emphasised. The purpose of this paper is to present the clinician with the many issues that elderly mental health faces in India today. (Lodha et al 2018).

In the research titled “Implications of Mental Healthcare Act 2017 for geriatric mental health care delivery: A critical appraisal” it is evident that as the population ages, mental health issues among elderly persons are becoming more prevalent globally and in India. The Mental Healthcare Act (MHCA) 2017 takes a rights-based approach and went into effect in India in May 2018. Its laws have important consequences for enhancing mental health care and preserving the rights of people with mental illnesses (PMI). Older persons with mental health disorders, such as dementia, are at significant risk of losing mental competence, being abused, having their rights violated, and being institutionalised. This act calls for the creation of specialised clinical services for older individuals in mental health care facilities. It also recognises PMI's rights to access a variety of services, including rehabilitation programs. Several articles of the act, such as those relating to mental ability, advance directives, nominated representatives, and obligations of other authorities, address specific issues for older individuals with mental illnesses. In this paper, we provide a critical assessment of the implications of MHCA 2017 in the context of care for older individuals with mental illnesses. (Sivakumar et al. 2019).

Geriatric populations and depression:

In the study titled “Study of depression among geriatric population in Nepal,” it is evident that the depression is one of the most common psychiatric diseases among older people who visit the tertiary care hospital's outpatient clinic. Neglected and untreated depression in the senior population may result in to excessive use of health care services, decreased treatment compliance, and increased morbidity and mortality from underlying medical illness and suicide. The study aims to figure out the prevalence of depression according to the Geriatric Depression Scale (GDS) and find out the association of GDS with ICD-10 Diagnostic Criteria for Research (ICD-10 DCR) among older persons in the Nepalese community. A sample of 100 elderly patients aged 65 and up were chosen at random from the psychiatry, medicine and general practice outpatient departments of Tribhuvan University Teaching Hospital in Nepal. The MMSE scale was administered, and patients with scores greater than 24 were given the GDS, and a clinical diagnosis was made using the ICD-10 DCR. According to GDS, 53.2% of the samples experienced depressive illness, including 34.2% mild depression and 19% severe depression. 83.3% of patients with probable depression on GDS were also clinically diagnosed with ICD-10 DCR ($p<0.001$). This study shows that a significant percentage of senior people who visit tertiary care hospitals' outpatient departments suffer from depression, and that GDS is a reliable method for screening depression in Nepali patients. (Khattri et al, 2006)

This study titled “Depression in geriatric population in urban slums of Mumbai” is about a community-based study was carried out in an urban slum in Mumbai to determine the epidemiological parameters linked with the geriatric population and depression. A sample size of 196 was selected using the lot's quality technique, which included all old people over the age of 60 in the study area. Depressed seniors (using the Geriatric Depression Scale) made up 45.9% of the study population, with females accounting for 57.8% ($p < 0.05$). Depression was significantly linked with poor socioeconomic position, marital status, non-working or dependent status, and illiteracy ($p < 0.05$). Depressed seniors were more likely to abuse substances (58.13%), have abnormal sleep patterns (61.6%), and experience acute/chronic disease ($p<0.05$). (Jain et al, 2007.)

In the research titled “Geriatric depression and cognitive impairment," cognitive impairment is frequently seen in cases of geriatric depression, and individuals with both depression and cognitive impairment face a higher risk of various adverse medical, psychiatric, and cognitive outcomes. This review examines the clinical issues related to the simultaneous occurrence of these two conditions in light of current research. We will discuss the clinical criteria and prevalence of depression, as well as co-occurring cognitive impairment. Additionally, we will explore factors associated with persistent cognitive impairment in depression, including the impact of dementia, and review relevant research on the assessment and treatment of cognitive impairment and dementia in the context of depression. Our findings suggest that current research on depression and cognition can guide clinical decisions to reduce the likelihood of negative outcomes. We encourage clinicians to adopt proactive treatment strategies that may include a combination of pharmacological and psychotherapeutic interventions (Steffens et al., 2008).

In the research titled “Study of Depression in Geriatric Population: Old Age Home and Community in Lucknow, India,” it suggests that as individuals live longer, households become smaller and more congested, generating stress in joint or extended families. This could lead to an old-age home settlement. Even when they live together, the elderly experience marginalisation, isolation, and insecurity as a result of generational and communication gaps. All of those conditions have an impact on the mental health of the elderly and can sometimes lead to depression. To investigate depression in elderly adults living in the community and in old age facilities. A cross-sectional descriptive study was conducted. The study population consisted of elderly individuals (age ≥60) living in old age facilities and communities in Lucknow, India. A multistage sample technique was implemented to include sufficient

respondents from the community, and all elderly people living in OAHs were included. The Geriatric Depression Scale, Hindi Version, was employed to diagnose depression in the elderly. The elderly who were single were depressed at a rate of 30.3%, compared to 14.0% among the married elderly. Depression was present in 27.7 percent of the elderly who lived in OAHs, compared to 15.6 percent of those who lived at home. Among the financially independent elderly, 10.0% were depressed, compared to 32.3% among those who were completely reliant. Depression was more common among the elderly living in OAHs than in the community. Similarly, it was more common among single people than among married and cohabiting couples. Financially independent seniors were less depressed. (Mohan et al., 2015)

This study titled "The Level of Depression among Older Adults Residing at Old Age Home and with the Family in an Urban Community of India," aimed to compare depression levels among older adults residing in an old age home and those living with their families in urban Kolkata. With the growing elderly population in India and shifting family structures, many older adults face isolation and insecurity, increasing their risk of depression. Data from 200 participants (100 from an old age home and 100 living with family) were assessed using the Geriatric Depression Scale. Findings revealed that severe depression was significantly more common among those in old age homes, who were four times more likely to experience it than those living with family. A significant relationship was also observed between age and depression level in both groups (Mahat, A. 2018)

The particular research titled "Depression among geriatric population; the need for community awareness" shows about the evaluation of the prevalence of depression among the rural elderly population of North Tamil Nadu, India, and to identify associated socioeconomic factors. A community-based cross-sectional study was conducted among those aged 60 and above. The data was collected from 162 adult participants selected through a multi-stage cluster sampling approach, using a structured interviewer-administered questionnaire and a Geriatric depression scale (short form), and the prevalence was measured. A binary logistic regression was applied to figure out the independent relationship between risk variables and depression. The study revealed that the prevalence of old age depression was 52.5% (95% CI: 44.7-60.3), with poor socioeconomic position, rising age, and single status all constituting a significant independent risk. The authors suggest for community-based support systems in rural areas, which will foster social involvement and involvement for the elderly. (Paul et al. 2019).

Depression in old age is an emerging public health concern that significantly impacts quality of life but remains underdiagnosed and undertreated. This study, titled "A comparative study of depression among the elderly living in old age homes and community in Visakhapatnam, India," aimed to assess and compare depression among elderly individuals residing in old age homes (OAHs) and those living in the community. A cross-sectional survey was conducted from October to December 2016 among 100 elderly participants—50 from OAHs and 50 from the community—using the validated Geriatric Depression Scale (GDS-15) in the local language. The findings revealed a significantly higher prevalence of depression among OAH residents (80%) compared to community-dwelling elders (52%) ($p=0.003$). In the community group, depression was significantly associated with marital status and chronic illness ($p<0.05$), whereas no such association was found among OAH residents. These results underline the need for routine mental health screening and support services for the elderly, particularly those in institutional settings. (Karini et al., 2019)

In this study titled "A Comparative Study between the Elder Population at Old Age Home and in their Own Home," Geriatric depression, a leading cause of morbidity and Disability Adjusted Life Years (DALYs), often goes undiagnosed, especially amid the shift from joint to nuclear family systems that weakens traditional support structures. This comparative study assessed depression among 170 elderly individuals aged ≥60 in Hubli-Dharwad, including those living in old-age homes and those residing with family. Using the Geriatric Depression Scale and direct interviews, the study found that 49.5% of participants were either mildly or severely depressed, with higher rates among females and residents of old-age homes. Education and socio-economic status were significantly associated with depression levels, highlighting the need for targeted mental health support for the elderly (Bant et al., 2020)

Depression is a significant public health issue among the elderly, leading to high morbidity and disability. This comparative cross-sectional study titled "Depression and its associated factors among elderly people of old age homes and community of Kathmandu district, Nepal: a comparative study" in Kathmandu district assessed depression and its associated factors among 122 elderly individuals from old-age homes and the community, using the Geriatric Depression Scale (GDS-15). The prevalence of depression was higher in old-age homes (74.6%) than in the community (41.8%), with residents of old-age homes being four times more likely to experience depression. Factors associated with depression included age in both settings, while additional factors varied: in old-age homes, lack of support, chronic illness, poor social relations, and stress were key; in the community, low income, neglect, and lack of involvement

in family decisions were significant. The findings highlight the urgent need for routine depression screening and targeted mental health interventions for the elderly, especially in institutional settings (Mali et al., 2021).

Geriatric populations and quality of life

This study titled "Assessment of quality of life in the oldest-olds living in nursing homes and at home" explored how the oldest-old (aged 85 and above) perceive their quality of life, comparing those living in nursing homes in Padova with those living at home. A total of 66 participants, with an average age of around 95, were assessed using two standard QoL questionnaires (PEQOL and LEIPAD). The results showed no major differences in overall quality of life between the two groups, except in self-care abilities—those in nursing homes had significantly lower scores in daily living activities. However, in areas like physical and mental health, social connections, and emotional well-being, perceptions were similar. Unlike younger elderly groups, the oldest-old seem to adapt well regardless of where they live, as long as they feel supported, whether by family or others (Urciuoli et al., 1998).

This study titled "A cross sectional comparative study assessing the quality of life in elderly living in old age homes and community and association of various factors with QOL " compared the quality of life (QOL) of elderly individuals living in old age homes and in the community, while also exploring the impact of various sociodemographic factors, spouse-related factors, habits, and hobbies. A total of 97 participants (49 from old age homes and 48 from the community) were assessed using a QOL scale. Results showed that higher QOL was linked to being well-educated, retired, in the middle socioeconomic class, free of unhealthy habits, and having a retired spouse in the "young old" age group. While QOL appeared slightly better among old age home residents, the difference was not statistically significant. However, several individual factors—especially socioeconomic status—showed a strong association with QOL, emphasizing the complex influences on well-being in later life. (Rayirala et al., 2016).

In this present study tilted "A comparative study of health status and quality of life of elderly people living in old age homes and within family setup in Raigad District, Maharashtra, the traditional Indian family structure, once a cornerstone of elderly care, is undergoing significant changes with the decline of joint families, leading to a growing reliance on old age homes (OAHs). This cross-sectional study aimed to compare the health status, quality of life (QOL), and depression levels among elderly individuals residing in OAHs and those living with their families. Using the WHOQOL-OLD questionnaire and the Geriatric Depression Scale (GDS),

data were collected from 60 elderly individuals in OAHs and 120 in family setups, matched for age, sex, and socioeconomic status. Findings revealed that the elderly living with families reported significantly better QOL across domains such as autonomy, engagement in activities, social participation, and intimacy. Additionally, depression scores were notably lower in the family group (mean score: 3.96) compared to those in OAHs (mean score: 5.76), indicating better mental well-being. Overall, the study highlights that elderly individuals residing within family environments experience a higher quality of life and lower levels of depression than their counterparts in old age homes (Amonkar et al., 2018).

In a study titled "A comparative study of quality of life among elderly people living in old age homes and in the community," ageing is influenced more by environmental, social, psychological, and cultural factors than by genetics alone, all of which impact quality of life (QoL). This cross-sectional study assessed and compared QoL among elderly individuals (>60 years) living in old age homes, urban, and rural areas using the WHOQoL-BREF questionnaire over three months. Results showed urban elderly had higher mean scores in physical, psychological, and social domains, while rural participants scored higher in the environmental domain. Psychological and environmental domains showed significant differences ($p=0.048$ and 0.001). Overall, urban elderly reported better QoL compared to rural and old age home residents (Kengnal et al., 2019).

A study tilted "A comparative study on quality of life of older adults" old age is a sensitive phase of life that demands support and adaptability. A descriptive comparative study in Kolkata, West Bengal, assessed the quality of life (QOL) among 100 elderly individuals—50 living in old age homes and 50 with their families. Using the Short-Form 36 Health Survey and the Multidimensional Scale for Perceived Social Support, the study found a significant difference in QOL scores between the two groups ($p < 0.05$). Interestingly, older adults in old age homes reported a better overall quality of life compared to those living with family, highlighting the potential benefits of structured care environments. (Mao et al., 2019)

In the present titled "Quality of life of elderly people living with family and in old age home in Morang District, Nepal", Nepal, like many other developing countries, is witnessing a rapid increase in its elderly population, making the quality of life (QOL) among older adults an important area of concern. Despite this demographic shift, limited information is available about the unique needs and QOL of elderly individuals, whether they live with family or in old-age homes. This cross-sectional descriptive study, conducted between October 2016 and

April 2017, aimed to assess and compare the QOL of 100 elderly people aged 60 and above, 50 residing in old age homes and 50 living with their families. The WHOQOL-BREF questionnaire was used to evaluate four key domains: physical, psychological, social, and environmental well-being. Findings revealed that better QOL scores were observed among elderly individuals in the 60–70 age group, males, married individuals, literates, and those with children. Elderly people living with their families scored higher in the physical, psychological, and environmental domains, indicating better overall well-being. However, the social relationship domain scored low across both groups, highlighting a shared sense of social disconnect, regardless of living arrangement. This suggests that social isolation is a common challenge for the elderly and needs to be addressed through community-based programs and social engagement initiatives. The study emphasizes that QOL is influenced by various personal and contextual factors and underscores the importance of supporting elderly people in ways that allow them to remain in their familiar home environments while staying socially connected and engaged (Shrestha et al., 2019).

In a study titled "A comparative study on quality of life of elderly among those living with families and in old age homes in a District in South India ", India's elderly population is rapidly growing and projected to triple by 2050. While healthcare advancements have improved physical health, the overall well-being of older adults often goes overlooked. This analytical cross-sectional study assessed the quality of life (QoL) in individuals over 60, comparing 40 elderly living with families and 40 in old age homes using the WHO-BREF QoL questionnaire. Most participants were male, with an average age of around 74. Results showed no significant difference in QoL between the two groups, although those in old age homes had slightly higher scores in psychological, social, and environmental domains. The findings highlight the importance of focusing more on these non-physical aspects to truly support the well-being of the elderly. (Vignesh et al., 2022).

Depression among the elderly is a growing public health issue. Depression, like other comorbidities, has an impact on older patients' quality of life and functional abilities. The purpose of this study titled "Depression and quality of life among elderly: Comparative cross-sectional study between elderly in community and old age homes in Eastern India" was to explore depression and quality of life among the elderly and compare those variables among the From March to July 2016, a cross-sectional survey was done among the elderly of the community and old-age homes in the urban regions of Raipur, Chhattisgarh. The study comprised 100 elderly individuals (50 in each group). The Geriatric Depression Scale 15 (GDS-

15) and Older People Quality of Life (OPQoL)-35 scales were used in assessing geriatric depression and quality of life, respectively. The association between depression and demographic characteristics was investigated using the Chi-square/Fisher's exact test. The Pearson correlation coefficient was calculated for the GDS-15 and OPQoL-35 scales. Geriatric depression was prevalent (59%). When compared to community elderly, old-age home elderly participants had a higher quality of life in terms of overall life score (11.78 vs. 13.56), health (12.8 vs. 14.0), social relationships (10.48 vs. 13.9), control over life (11.92 vs. 14.08), home and neighbourhoods (9.38 vs. 12.36), psychological and emotional wellbeing (10.96 vs. 13.7), financial circumstances (14.5 vs. 16.7), and leisure and activities (13.86 vs. 15.28). A moderate positive association was found between depression and quality of life. The increased incidence in our study emphasises the importance of defining the actual burden in the senior population and implementing essential supportive measures (Sahoo et al,2022).

In the study titled "A comparative study of quality of life of elderly living in old age homes and within family " indicates that with the decline of traditional joint family structures in India, more elderly individuals are turning to old age homes (OAHs) for support. However, limited data exists on the quality of life (QOL) among this population. This cross-sectional study aimed to understand the reasons behind the transition to OAHs and compare QOL across physical, psychological, social, and environmental domains between elderly individuals living in OAHs and those residing with family. Using the WHOQOL-BREF questionnaire, 100 participants from OAHs and 200 from family setups were assessed, matched by age, sex, and socioeconomic status. Results showed that physical (40.9) and environmental (35) domain scores were higher among those living with family, while social (55.7) and psychological (51.3) domains were significantly better among OAH residents ($p<0.05$). The study concludes that while family support positively impacts health, enhancing the structure and support systems within OAHs can also lead to improved QOL for the elderly in the absence of traditional family setups (Soni et al., 2024).

Geriatric populations and Hope:

This study, "Hope in older adults in community and institutional settings," examined the concept of hope and how specific background characteristics influence it. It also identified strategies to promote hope among a convenience sample of 60 older adults using methodological triangulation, which included interviews, the Hope Index, and a Background Data Form. The participants described hope as the expectation of a brighter future for

themselves and/or others. It was found that perceptions of hope were influenced by factors such as place of residence, age, energy level, functional ability, and health status. With the exception of participants experiencing severe fatigue and those living in long-term care facilities, overall levels of hope among the subjects were high and remained stable across different background variables. The study identified eight categories that foster hope and four categories that hinder it based on the interview responses. The implications for practice and future research are also discussed. (Herth et al., 1993).

This study, titled "*A study of hope in a group of community-dwelling older adults,*" used a non-experimental, descriptive, and correlational design to explore levels of hope among 40 community-dwelling older adults from a senior centre in a rural Midwest town. Participants completed the Miller Hope Scale and provided demographic information, including age, gender, income, education, health status, and medical conditions. Most were elderly women with activity-limiting conditions who still rated their overall health as good. Overall, the group showed high levels of hope. However, no significant relationship was found between hope and variables such as age, years retired, or income. (Karns et al., 1996).

This study titled "Depression, hopelessness, and suicidal ideation among the elderly: A comparison between men and women living in nursing homes and in the community" explores how depression, hopelessness, and suicidal thoughts vary between elderly men and women based on their living arrangements—whether they live in the community or in nursing homes. Aging often brings a range of losses—physical, cognitive, social, and financial—that can lead to loneliness, anxiety, and a diminished will to live. As life expectancy increases, a growing number of older adults will likely spend part of their lives in long-term care settings. Unfortunately, such transitions can negatively affect mental health, often due to a loss of autonomy and control. The study involved 318 participants: 227 community-dwelling seniors (78 men, 149 women) and 91 nursing home residents (33 men, 58 women), including individuals with varying levels of independence. The results revealed that nursing home residents experienced significantly higher levels of depression, hopelessness, and helplessness. Gender differences were observed across both living environments, and other demographic factors were also linked to mental health outcomes. These findings highlight the urgent need for interdisciplinary support focused on the mental well-being of nursing home residents, especially during the early stages of adjustment (Ron et al., 2004).

The aim of this pilot study titled “Exploring the links between depression, integrity, and hope in the elderly” was to explore the connections between depression, integrity, and hope in the elderly. We recruited a voluntary sample of cognitively intact elderly patients receiving psychiatric care (n = 35). Participants were drawn from three sources: an inpatient geriatric psychiatry unit (n = 14), a geriatric psychiatry day program (n = 6), and an outpatient geriatric psychiatry service (n = 15). Each participant completed a questionnaire that measured depression using the Geriatric Depression Scale Short Form (GDSSF), integrity with the Sense of Coherence Scale-Short Form (SOC-13), and hope through the Hope Differential-Short (HDS) and the Hope Numerical Rating Scale (Hope-NRS). The HDS is comprised of three separate subscales: Personal Spirit, Risk, and Authentic Caring. We analyzed the data using descriptive statistics, t-tests, and Pearson correlations. Patients without depression (n = 17) exhibited a greater sense of coherence (SOC) ($P < 0.01$), higher levels of hope (Hope-NRS, $P < 0.05$), enhanced Personal Spirit (HDS subscale, $P < 0.05$), and increased risk-taking (HDS subscale, $P < 0.01$) compared to patients with depression (n = 18). The two variables that correlated most strongly with depression were SOC ($r = -0.65$, $P < 0.01$) and Risk (HDS subscale, $r = -0.62$, $P < 0.01$). These findings suggest that depression, integrity, and hope are highly interrelated in the elderly population and may influence their ability to navigate the developmental tasks of aging. Further research is necessary to gain a deeper understanding of these complex experiences in late life (Chimich et al., 2004).

The primary aim of this study titled “Living with hope: initial evaluation of a psychosocial hope intervention for older palliative home care patients” was to assess the effectiveness of a psychosocial supportive intervention known as the “Living with Hope Program” (LWHP) in enhancing hope and quality of life for older adults who are terminally ill with cancer and living in the community. Using a mixed-method, concurrent nested experimental design, a total of 60 terminally ill cancer patients aged over 60 years were randomly assigned to either a treatment group or a control group. Baseline measurements of hope (using the Herth Hope Index [HHI]) and quality of life (using the McGill Quality of Life Questionnaire [MQOL]) were collected during the first home visit conducted by trained research assistants. Participants in the treatment group engaged with the LWHP, which included watching an internationally award-winning video on hope and selecting one of three hope-related activities to work on over the course of a week. The control group received standard care. One week later, hope and quality-of-life data were gathered from both groups. Additionally, qualitative data were collected from the treatment group through open-ended questions related to hope. Results showed that patients in

the LWHP group had statistically significant higher levels of hope (U = 255, P = 0.005) and improved quality-of-life scores (U = 294.5, P = 0.027) compared to those in the control group. Qualitative feedback indicated that the majority (61.5%) of patients in the treatment group believed the LWHP had increased their sense of hope. This preliminary evaluation suggests that the LWHP may effectively boost both hope and quality of life for older terminally ill cancer patients living at home. (Duggleby et al., 2007).

This study named " Effect of Self-Care Ability and Life Satisfaction on the Levels of Hope in Elderly People" aimed to examine the impact of self-care ability and life satisfaction on levels of hope among elderly individuals. The research was conducted at three family healthcare centers in Malatya from November 20, 2014, to January 1, 2015. The study population consisted of 4,181 people aged 65 and older, selected from three out of ten family healthcare centers in Malatya through a random selection process. Based on a 0.05 margin of error at a 0.95 confidence interval, the sample size was determined to be 320 elderly individuals, with each healthcare center considered a separate cluster. Çarmuzu Family Healthcare Center served 1,653 elderly individuals, Özalper Family Healthcare Center had 1,939, and Tevfik Ünsalan Family Healthcare Center had 589. Population weighting was performed for these clusters, and 127 elderly individuals were randomly selected from Çarmuzu, 148 from Özalper, and 45 from Tevfik Ünsalan. Data were collected using an introductory information form, the Self-Care Ability Scale, the Life Satisfaction Scale, and the Hope Scale. A statistically significant positive relationship was found between self-care ability and life satisfaction, as well as between self-care ability and hope. However, no statistically significant relationship was observed between life satisfaction and hope. This suggests that elderly individuals with higher self-care abilities tend to view the future with more hope. Elderly individuals often require assistance in fulfilling their daily self-care needs. Therefore, it is important to develop social support systems and educational programs aimed at promoting care for elderly people in home settings. (Erci et al., 2017).

This study, titled "The Study of Subjective Well-Being and Hope Among Elderly People," explored the relationship between hope and subjective well-being, comparing elderly individuals living in old age homes with those living with their families in Kanpur, Uttar Pradesh. A total of 151 participants aged 60 and above were randomly selected—79 from old age homes and 72 from family settings. Each participant completed the Subjective Well-being Inventory (1992) and the Adult Hope Scale (1991). Surprisingly, the results showed that institutionalized elderly reported higher levels of overall well-being and hope compared to

those living with their families, who showed greater signs of ill-being. While age groups did not differ significantly in subjective well-being, institutionalized elders showed varying levels of hope across different age brackets. Overall, the study found a significant positive correlation between hope and subjective well-being, highlighting the importance of nurturing hope in later life, regardless of living arrangement (Gupta et al., 2019).

In the research titled "A Comparative Study on Effect of Motivation and Hope on the Well-being of Geriatric Population," for the last decade, researchers have focused significantly on both physical and mental health, particularly concerning the geriatric population, which faces various challenges associated with aging. This study examines how motivation and hope can enhance overall well-being in elderly individuals. To assess the effects of motivation levels, hope, and well-being among seniors, the research was conducted in societies within the Delhi-NCR region. The study included a sample size of 60 elderly participants, comprising both men and women, with 30 individuals suffering from hypertension (experimental group) and 30 healthy elderly individuals (control group). Data were collected using the Elderly Motivational Scale, the Adult Hope Scale, and the Ryff Psychological Well-Being Scale. The findings revealed that the well-being of the hypertensive group was higher than that of the healthy elderly group. (Sharma et al., 2020).

A total of 36 studies were included in the review titled "A systematic review of interventions for hope/hopelessness in older adults," which states that most of these studies considered hope and hopelessness as secondary outcomes. The findings indicated that interventions based solely on Cognitive Behavioural Therapy (CBT), or a combination of CBT and antidepressants, significantly reduced feelings of hopelessness in depressed older adults. Additionally, psychological interventions that utilized life review techniques effectively improved hope and alleviated hopelessness across various samples, including those who were depressed, grieving, or dealing with medical issues. However, the review found little to no evidence supporting the effectiveness of exercise programs for healthy older adults, educational interventions for medically ill patients, or Dignity Therapy for individuals in palliative care. Overall, it suggests that the hope and hopelessness levels in older adults can be enhanced through psychological interventions that incorporate CBT and life review strategies. Notably, further controlled trials focusing on hope and hopelessness as primary objectives are necessary to clearly evaluate their effectiveness. The evidence indicates that cognitive-behavioural interventions can alleviate hopelessness in depressed older adults, and that life review-based interventions can positively influence hope in various older populations. Conversely, it appears that Dignity Therapy,

physical exercise, and educational programs may not significantly improve hope or reduce hopelessness among older adults. (Hernandez et al., 2021).

Hope plays a vital role in human life, often described as a key force that sustains us through challenges. As Snyder (1994) put it, hope is "the process of linking oneself to potential success." Across disciplines—philosophy, psychology, and even poetry—hope is recognized as essential for well-being and resilience (Farran, 1985). This study titled "Measurement of Level of Hope among Institutional and Non-Institutional Elderly: A Comparative Study," aimed to examine the level of hope among elderly individuals living in institutions (old age homes) versus those living at home in Dehradun, Uttarakhand. A total of 180 older adults voluntarily participated in the study. They completed the Adult Hope Scale (Snyder et al., 1991), which measures an individual's sense of hope. Findings revealed that elderly individuals living at home reported significantly higher levels of hope than those in old age homes. Higher hope was also linked to greater psychological well-being, including a stronger sense of purpose, life satisfaction, and positive emotions. Gender differences were also observed, suggesting that men and women experience and express hope differently depending on their living situation (Pandey et al., 2021).

Geriatric populations and cognitive impairments:

To investigate the meaning of cognitive impairment in community-dwelling elderly individuals, a study titled "The meaning of cognitive impairment in the elderly", was conducted where 3,481 adults were interviewed in their homes using the Mini-Mental State Examination. Among the population aged 18 to 64, 96 percent scored 23 or higher. In contrast, only 80 percent of those aged 65 and over achieved the same score. Those who scored lower were often experiencing a range of psychiatric disorders, including dementia. Notably, 33 percent of the elderly individuals who scored between 0 and 23 did not have a diagnosable condition according to DSM-III criteria. The overall prevalence of dementia from all causes among those over 65 years of age was found to be 6.1 percent, and 2 percent of this population was diagnosed with Alzheimer's disease. (Folstein et al., 1985).

A study titled "Cognitive decline in an elderly population–a two-wave study of change" examined 1,111 survivors aged 75 and older, highlighting alarming trends in cognitive decline, as measured by the Mini-Mental State Examination (MMSE). Over an average of 28 months, participants experienced an average decline of 1.3 points in their MMSE scores, with declines becoming more pronounced with age. The percentage of individuals newly classified as

cognitively impaired rose notably with age, particularly among women, even after adjusting for age. While cognitive changes followed a normal distribution, the MMSE scores themselves were skewed due to truncation at the maximum score. Importantly, the decline was not linked to physical impairments. These findings reveal that cognitive decline, akin to dementia, is increasingly common among older adults, positioning dementia as one extreme on a broader spectrum of cognitive deterioration. This calls for greater awareness and targeted interventions to address the challenges posed by cognitive decline in our aging population. (Brayne et al., 1995).

This paper titled "Assessing quality of life in older adults with cognitive impairment", examines the theoretical, psychometric, and practical aspects of assessing quality of life in older persons with cognitive impairment. It introduces the QOL-AD, a new measure of quality of life in dementia, and investigates the reliability and validity of patient and carer reports on patient quality of life. The study included 177 patient-caregiver pairs. Patient Mini Mental State Exam scores varied from 0 to 29, with an average of 16 (SD = 7). Each patient and carer appraised the patient's quality of life using the QOL-AD. Patient functional and cognitive status, psychological mood, physical function, and behavioural issues were all evaluated. The reliability and validity of patient QOL-AD reports were assessed at three levels of cognitive impairment. One hundred fifty-five patients successfully completed the QOL-AD. Completers scored between 4 and 29 on the Mini Mental State Exam, whereas non-completers all scored 10 or lower. The reliability of patient and carer reports on QOL-AD was good (α values varied from 0.83 to 0.90). Correlations between patient and carer reports and depression ($r = -0.41$ to -0.65), daily functioning ($r = -0.10$ to -0.45), and frequency of happy occurrences ($r = 0.18$ to 0.51) confirmed their validity across cognitive levels. The intraclass correlation between patient and carer reports was positive at all cognitive levels ($r = 0.14$–0.39). The QOL-AD seems to be reliable and valid for individuals with MMSE scores greater than 10. Further research is needed to clarify the relationship between patient and caregiver reports of patient quality of life and to identify factors that influence quality of life throughout the progression of dementia. (Logsdon et al, 2002).

In this study titled " A cross-sectional comparative study assessing the psychiatric morbidity in elderly living in old age homes and community," it is showed that in recent years, India has witnessed a shift in the traditional family structure, with more elderly individuals moving from joint families into old age homes. This study aimed to compare the socio-demographic factors and psychiatric conditions of elderly people living in old age homes versus those living in the

community. A total of 100 participants—50 from each group—were assessed using the Geriatric Mental Status Questionnaire after obtaining informed consent. The findings revealed significant differences between the two groups in factors such as age, education, income, marital status, and whether they had male or employed children. Mental health issues also varied: anxiety, moderate depression, obsessions, and alcohol use were more common among community-dwelling elders, while those in old age homes showed more mild depression, cognitive decline, and physical complaints. However, these mental health differences were generally not statistically significant, except for alcohol use, which was notably higher in the community group (Rayirala et al, 2014).

In the research titled "A Comparative Study to Assess Cognitive Impairment of Old People Residing in Old Age Home Versus those Living with the family in Pune City", it states that aging encourages wisdom but also presents problems. Older adults face unique challenges compared to younger individuals. Research on homeless and geriatric care suggests cognitive impairments in old age. The researcher conducted a study in Pune, India, comparing cognitive impairment among elderly residents of old age homes and those living with their families. The study found that 72% of elderly residents in old age homes had mild cognitive impairment, 17% had moderate cognitive impairment, and 10% had normal cognitive abilities. Among elderly people living with their families, 70% had mild cognitive impairment, 30% had normal cognitive function, and none had severe or moderate cognitive impairment. There is no association between cognitive impairment and age, gender, marital status, educational position, or type of family among elderly individuals living with their families, as their cognitive abilities were mild to normal. (Gautam et al,.2016)

This study, titled "Functioning and cognition of Portuguese older adults attending residential homes and day centers: a comparative study", compared the cognitive and functional abilities of institutionalized and non-institutionalized older adults, analysing how factors like age, gender, and education influence these outcomes. Data from 593 participants, assessed using the Elderly Nursing Core Set and Mini Mental State Examination, showed that women, those without formal education, and residents of care homes had higher levels of cognitive and functional impairment. Cognitive decline increased with age, while functional issues were more common among institutionalized individuals regardless of age. The findings highlight the need for lifelong health education and community-based support to help older adults maintain independence and quality of life (Lopes et al., 2021).

This study, titled “A comparative study on psychiatric morbidity among elderly population residing in old-age homes and community”, aimed to compare the socio-demographic profile, psychiatric morbidity, cognitive function, quality of life, and social support of elderly individuals living in old age homes and in the community. A total of 100 participants (50 from each group) were assessed using standardized tools, including the Geriatric Mental Status Questionnaire, Mini-Mental State Examination, Quality of Life Scale, and Perceived Social Support Scale. Findings revealed that old age home residents were more likely to lack a spouse or children and expressed a more accepting attitude toward death. They also had a higher history of psychiatric illness and showed more cognitive and psychological symptoms such as memory issues, somatic concerns, and thought disturbances. Interestingly, despite these challenges, their quality-of-life scores were higher than those of community-dwelling elders. The study underscores the need to raise awareness about mental health in older adults and to improve access to geriatric and mental health services in both institutional and community settings (Saritha et al., 2022).

From the above literature review, it is seen that there are several gaps in how depression, hope, quality of life, and cognitive impairments are interrelated. While cognitive impairment is commonly examined, less attention is given to how depression and hope influence cognitive decline and overall wellbeing, especially in different living conditions like old age homes and in own home. Here also doesn’t have enough research that looks at different stages of cognitive development and its effects on emotional well-being and quality of life. Many studies assess quality of life, but they aspects like emotional well-being, social connections, and autonomy.

Chapter 3

METHODOLOGY

METHODOLOGY

Research methodology is a way to systematically solve the research problem. It may be understood as a science of studying how research is done scientifically. It refers to specific procedures or techniques used to identify, select, process, and analyse information about a topic.

The present study focuses on some psychological aspects like depression, quality of life, and levels of hope (mainly focusing on agency and pathway thinking) among elderly individuals (60 years and above) who are staying at home with their loved ones and those who are staying at old age residences with administering the Mini-mental status examination. The purpose of the study is to measure how much these psychological aspects, like depression, quality of life, hope, and cognitive abilities, vary among elderly individuals, which may impact their day-to-day living.

This study has been made to compare elderly individuals staying at home and elderly individuals staying at the old age home based on some aspects like depression, levels of hope (agency and pathway thinking), quality of life (measuring physical well-being, psychological well-being, social relationships, and environmental factors.

The standardized tools are regarded as the basis for a shred of evidence for assessments. It is a type of evaluation tool that provides the means for establishing statistical reliability and validity. Established and standardized tools evaluate responses in a way through which resulting dimensions can be operationally defined.

The level of depression has been measured by the Geriatric Depression Scale- short form (GDS-15) by (Sheikh and Yesavage in 1986), and the level of quality of life has been measured by the Quality of Life Scale (QOLS -16) by (Carrol S. Burkhardt in 1989), the levels of hope has been measured by the 12 items trait hope scale by (C.R.Snyder, 1991) and the measure of cognitive impairments was measured using the Mini-Mental Status Examination (MMSE) by (Folstein et al.,1975) which measures several dimensions like orientation, registration, attention and calculation, recall and language.

OBJECTIVES

The present study was aimed,

1. To find out if there is any significant difference between the elderly people living in their homes and the elderly people living in old age residences with respect to depression.
2. To find out if there is any significant difference between the elderly people living in their homes and elderly people living in old age residences with respect to quality of life.
3. To find out if there is any significant difference between the elderly people living in their homes and elderly people living in old age residences with respect to hope-agency.
4. To find out if there is any significant difference between the elderly people living in homes and the elderly people living in old age residences with respect to the hope-pathway.
5. To find out if there is any significant difference between the elderly living in their homes and the elderly living in the old age residences with respect to Hope total.
6. To find out if there is any significant difference between the elderly people living in their homes and the elderly people living in old age residences with respect to cognitive impairments.

HYPOTHESIS

On the basis of previous studies, the following hypotheses are formulated-

H1: There is a significant mean difference between elderly people living in their homes and elderly people living in old age residences with respect to depression.

H2: There is a significant mean difference between the elderly people living in their homes and the elderly people living in old age residences with respect to quality of life.

H3: There is a significant mean difference between the elderly people living in their homes and the elderly people living in old age residences with respect to hope agency

H4: There is a significant mean difference between the elderly people living in their homes and the elderly people living in old age residences with respect to hope pathway.

H5: There is a significant mean difference between the elderly people living in their homes and elderly people living in old age residences with respect to hope total.

H6: There is a significant mean difference between the elderly people living in their homes and elderly people living in old age residences with respect to cognitive impairment.

For the present study, these definitions have been defined operationally.

OPERATIONAL DEFINITIONS

Mental health: "Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It has intrinsic and instrumental value and is integral to our well-being" (WHO).

Aging: "Aging refers to the progressive accumulation of changes over time that are associated with or responsible for the increased susceptibility to disease and death" (American Psychological Association, n.d)

Senior citizen: "An older adult, especially one who is retired or has reached the age of retirement (generally 65 years or older)" (American Psychological Association, n.d)

Gero-psychology: "A specialization in psychology dealing with enhancing the welfare and mental health of older adults via the provision of various psychological services. Also called geriatric psychology" (American Psychological Association, n.d)

Depression: "A negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life. Various physical, cognitive, and social changes also tend to co-occur, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities. It is symptomatic of the number of mental health disorders" (American Psychological Association, n.d).

Quality of life: "Quality of Life is defined as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHO).

Hope: "the expectation that one will have positive experiences or that a potentially threatening or negative situation will not materialize or will ultimately result in a favourable state of affairs.

Hope has been characterized in the psychological literature in various ways, including as a character strength; an emotion; a component of motivation that is critical to goal attainment; a mechanism that facilitates coping with loss, illness, and other significant stresses; or an integrated combination of these features" (American Psychological Association, n.d).

Cognitive deficits: "Cognitive deficit**"** is an inclusive term used to describe the impairment of different domains of cognition. Cognitive deficit is not limited to any particular disease or condition but may be one of the manifestations of someone's underlying condition. It is also used interchangeably with "cognitive impairment." It might be a short-term condition or a progressive and permanent entity" (National Institute Of Health, NIH).

Retirement home: "A house or apartment in which a person lives in old age, especially one in a group of homes specially designed for older people" (Oxford dictionary).

Hope pathway: "The perceived capacity to generate plausible routes or strategies to achieve goals". (Snyder, et al., 2002)

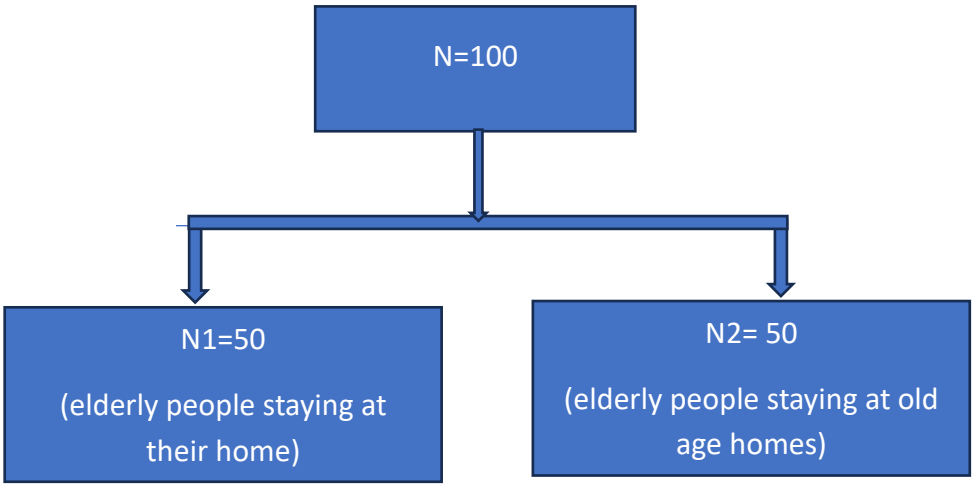
Hope agency: "The motivational components that drive individuals to initiate and sustain movements along these pathways towards goal achievements". (Snyder et al., 2002)

METHODS:

Sample :

The purposive sampling method was used for the present study. In this research, a total of 120 participants participated. Out of which 9 participants did not return the questionnaire, and 11 did not sign the consent form. From this, 100 participants were selected, out of which 50 participants were from the old age homes and 50 stayed in their own houses with their family. All the participants were selected from Kolkata and its surrounding area.

The number of participants was assigned to different groups based on staying at an old age home and staying at their own houses, which were categorized as:



The research participants were selected based on the following inclusion and exclusion criteria.

Inclusion criteria:

- The age range must be 60 and above
- Participants must be staying at old age residences or in their homes.

Exclusion criteria:

- people below the age of 60 years.
- subjects having physical (except high blood pressure and arthritis) or psychological disorders.
- Those who are from the psychology field.

DESCRIPTION OF THE TEST

I. Demographic details:

An information schedule was used to gather demographic details – name, age, sex, residence (urban/rural/suburban), education, occupation, working or retired, family type (nuclear/joint), marital status, spouse details (spouse age, living or dead, relationship with the spouse), children's details (how many children the subject have), does the subject currently under any medications for physical or psychological disorders, history of any chronic physical or psychological illness.

II. Geriatric Depression Scale – short form (GDS-15):

Description of the test:

The Geriatric Depression Scale (GDS), first created by Yesavage et al., has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no about how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986. Questions from the Long Form GDS, which had the highest correlation with depressive symptoms in validation studies, were selected for the short version.

Administration:

This is a self-administering questionnaire. Participants are asked to put yes or no beside each item that best describes them. Participants need to rate each item on the basis of what they have experienced over the past week.

Scoring:

Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression.

Reliability and validity:

The GDS was found to have a 92% sensitivity and an 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of

the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults, with a high correlation ($r = .84$, $p < .001$).

III. Quality of life scale (QOLS-16)

Description of the test:

The quality-of-life scale (QOLS) was created originally by American Psychologist John Flanagan in the 1970s. The test was originally a 15-item instrument that measures five conceptual domains of quality of life: material and physical wellbeing, relationship with other people, social community and civic activities, personal development and fulfilment, and recreation. After descriptive research, the instrument was expanded to include one more item, i.e., independence, the ability to do for yourself. Thus, the QOLS in its present format contains 16 items developed by Carrol S. Burckhardt et al. (1989).

Administration:

The Quality-of-Life Scale is a self-report questionnaire that is rated on the basis of a 7-point Likert scale. Participants are asked to circle the number beside each question that best describes how satisfied they are at this time, even if they do not currently participate in the activity or have a relationship. It can either be completed in a clinic setting or by mail. It can also be completed in an interview format. If the interview format is chosen, individuals should be given a copy of the 7-point response to refer to when making their decisions as to the most appropriate point on the scale. The rating scale is as follows-

1- Terrible
2- Unhappy
3- Mostly dissatisfied
4- Mixed
5- Mostly satisfied
6- Pleased
7- Delighted

Scoring:

The QOLS is scored by adding up the scores on each item to yield a total score for the instrument. Scores can range from 16-112. There is no automated administration or scoring

software for the QOLS. A higher score indicates a higher quality of life. The average total score for healthy populations is about 90.

Reliability and validity:

The reliability and validity for the quality-of-life scale is internally consistent (Cronbach's alpha = 0.82 to 0.92) and high test-retest reliability (r =0.78 to 0.84).

IV. The adult trait hope scale

Description of the test:

The adult trait hope scale was developed by C.R. Snyder, 1991. The scale consists of 12 items with two subscales i.e., agency thinking and pathway thinking. This scale consists of four agency items, four pathway items, and four distractor items. This is a self-report questionnaire used to measure the general level of hope. Items for the agency subscale are 2,9,10, and 12, and items for the pathway subscale are 1,4,6, and 8.

Administration:

The adult trait hope scale is a self-report questionnaire that is based on the 8-point Likert scale. Participants are asked to select the number that best describes them. The rating scale is as follows-

1. Definitely false
2. Mostly false
3. Somewhat false
4. Slightly false
5. Slightly true
6. Somewhat true
7. Mostly true
8. Definitely true

Scoring:

The adult hope scale is derived by summing the scores of the items within each subscale (agency and pathway). The scores of item numbers 2, 9, 10, and 12 are to be added, and the scores of item numbers 1,4,6, and 8 are to be added to get the total adult hope score. Scores on

each subscale can range from 4 to 32. Scores of the total hope can range from 8 to 64, which states higher score indicates a higher level of hope.

Scores range from-

40-48 = hopeful

48-56- moderately hopeful

56 and higher= highly hopeful

Reliability and validity:

This instrument demonstrates both internal reliability (alphas ranging from 0.74-0.88 for the overall scale, and alphas of 0.70-0.84 for the agency and 0.63-0.86 for pathways subscales separately) and temporal reliability (test-retest ranging from .85 for 3 weeks to 0.82 for 10 weeks.

V. Mini Mental Status Examination (MMSE)

Description of the test:

Mini Mental Status Examination was developed by Folstein et al, 1975. The MMSE is effective as a screening tool for cognitive impairment in older adults, community-dwelling, hospitalized, and institutionalized adults. Assessment of an older adult's cognitive function is best achieved when it is done routinely, systematically, and thoroughly. The Mini Mental State Examination (MMSE) is a tool that can be used to systematically and thoroughly assess mental status. It is an 11-question measure that tests five areas of cognitive function: orientation (time and place), registration (memory), attention and calculation, recall (memory), and language. It can be effectively used both in clinical settings and research contexts.

Administration:

This test is an 11-question measure where participants were informed about the purpose of the MMSE. Participants are asked to sit comfortably. The MMSE takes only 5-10 minutes to administer and is therefore practical to use repeatedly and routinely.

Scoring:

MMSE is scored based on 5 domains, which are orientation, registration, recall, attention, calculation, and language. The total score of the MMSE ranges between 0-30.

Individual domain scoring is as follows-

Orientation to time- 5 points

Orientation to place- 5 points

Registration- 3 points

Attention and calculation- 5 points

Recall- 3 points

Language – 9 points

The maximum score for MMSE is 30. A score of 23 or lower is indicative of cognitive impairment.

Reliability and validity:

The internal consistency of the MMSE method was represented by Cronbach's alpha at the level of 0.78. The MMSE sensitivity was good, and that was at the level of 0.83 with a confidence interval of 95% from 0.62 to 0.95.

PROCEDURE FOR THE DATA COLLECTION

All the participants were contacted personally, and rapport was established before collecting the data, and consent forms were signed. They were given the brief about the aim of the present study. Instruction was given according to the used questionnaire. They were assured that their information would be kept confidential and used only for research purposes, so they were requested to be open and honest in their responses. After that, scales were administered and data were collected.

STATISTICAL ANALYSIS

For the analysis of the present study, Jamovi software, version 2.3.28 was used. Shapiro-Wilk, descriptive statistics including mean and standard deviation were calculated to understand the general trends and distribution of the variables. An independent sample t -test was used to compare the results between home-living individuals and residents of an old age home to find out whether the results come to be significant or insignificant.

Chapter 4

RESULTS

TABLE 1: RESULTS ON NORMALITY OF THE DISTRIBUTION

	Residence	**Depression**	**Quality of life**	**Hope-agency**	**Hope-pathway**	**Total Hope**	**Cognitive Impairment**
N	Home living	50	50	50	50	50	50
	Residence of an old-age home	50	50	50	50	50	50
Mean	Home living	5.46	85.6	22.6	24.5	47.5	25.5
	Residence of an old-age home	7.46	83.1	22.0	21.4	41.5	22.0
Skewness	Home living	0.665	-0.536	0.112	0.0163	0.0916	0.440
	Residence of an old-age home	0.125	0.0758	0.391	-0.393	-0.518	0.435
Standard error of skewness	Home living	0.337	0.337	0.337	0.337	0.337	0.337
	Residence of an old-age home	0.337	0.337	0.337	0.337	0.337	0.337
Kurtosis	Home living	0.395	0.0134	0.696	-1.12	-0.888	0.213
	Residence of an old-age home	0.806	-0.842	0.584	0.200	-0.344	0.190
Standard error	Home living	0.662	0.662	0.662	0.662	0.662	0.662

of kurtosis	Residence of an old-age home	0.662	0.662	0.662	0.662	0.662	0.662
Shapiro-wilk W	Home living	0.935	0.958	0.971	0.950	0.967	0.936
	Residence of an old-age home	0.958	0.972	0.962	0.977	0.964	0.972
Shapiro-wilk P	Home living	0.009	0.074	0.264	0.036	0.177	0.009
	Residence in an old-age home.	0.077	0.280	0.110	0.423	0.130	0.274

Table No.1 indicates that the Shapiro-Wilk P value is not significant. The sample is normally distributed.

PLOTS:

FIG -1: The graphical representation of the normality of distribution (Depression)

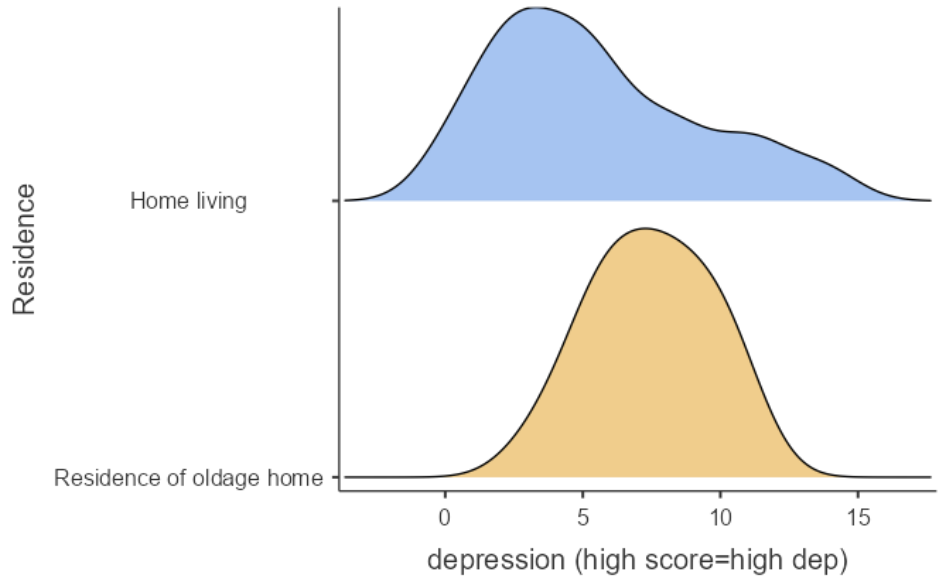


FIG-2: The graphical representation of the normality of distribution (Quality of life)

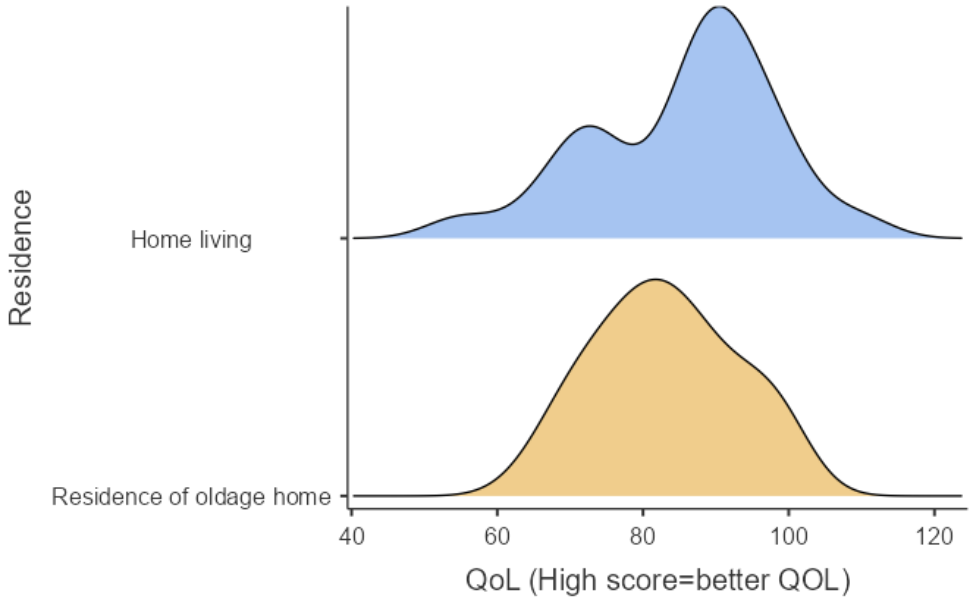


FIG-3: The graphical representation of the normality of distribution (Hope-Agency)

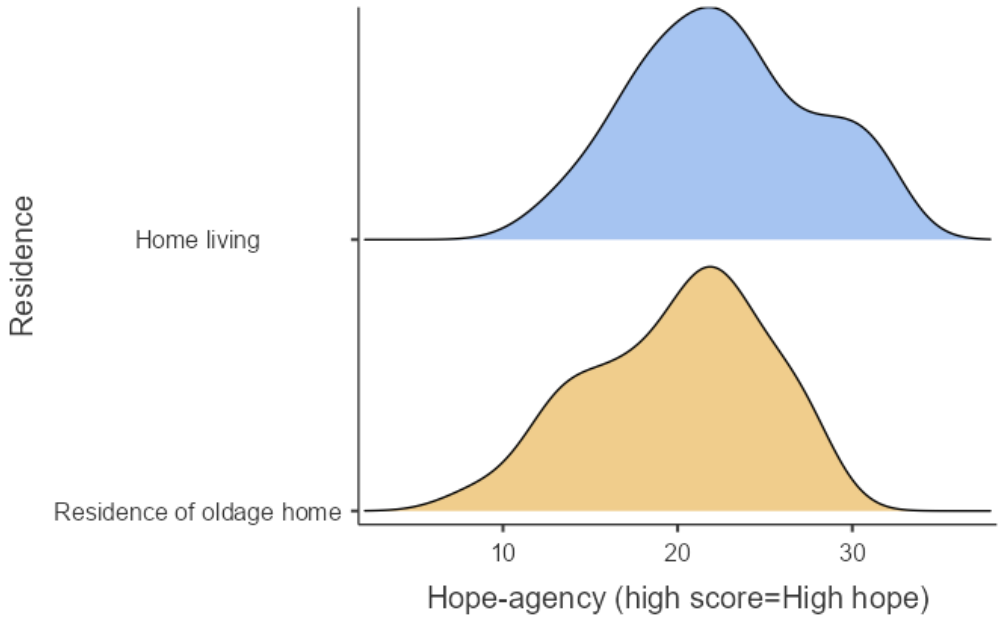


FIG-4: The graphical representation of the normality of distribution (Hope-pathway)

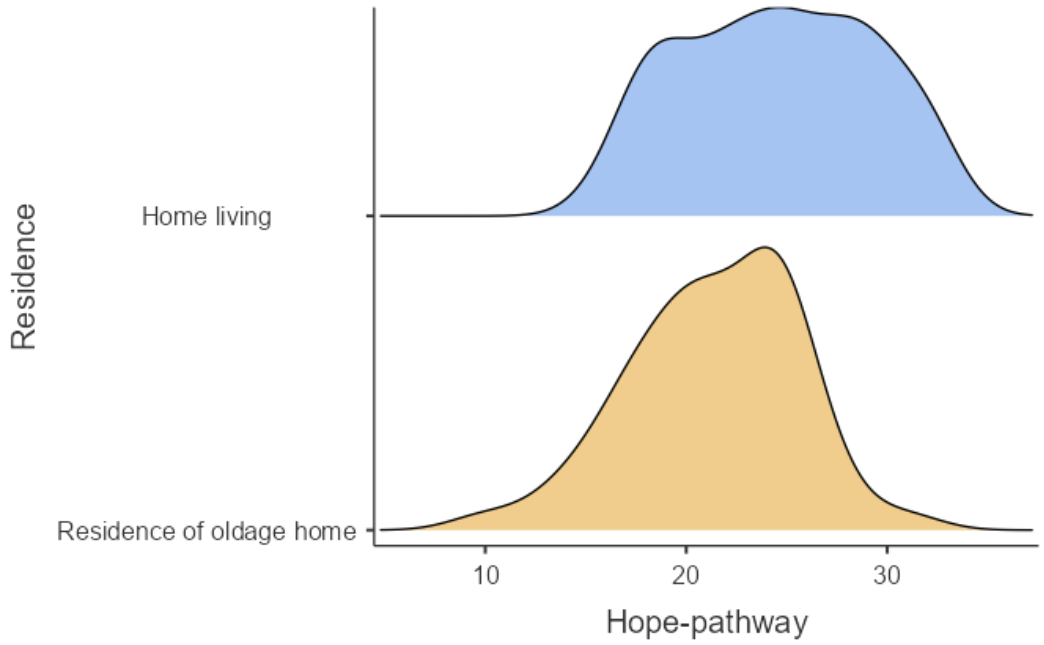


FIG-5: The graphical representation of normality of the distribution (Total hope)

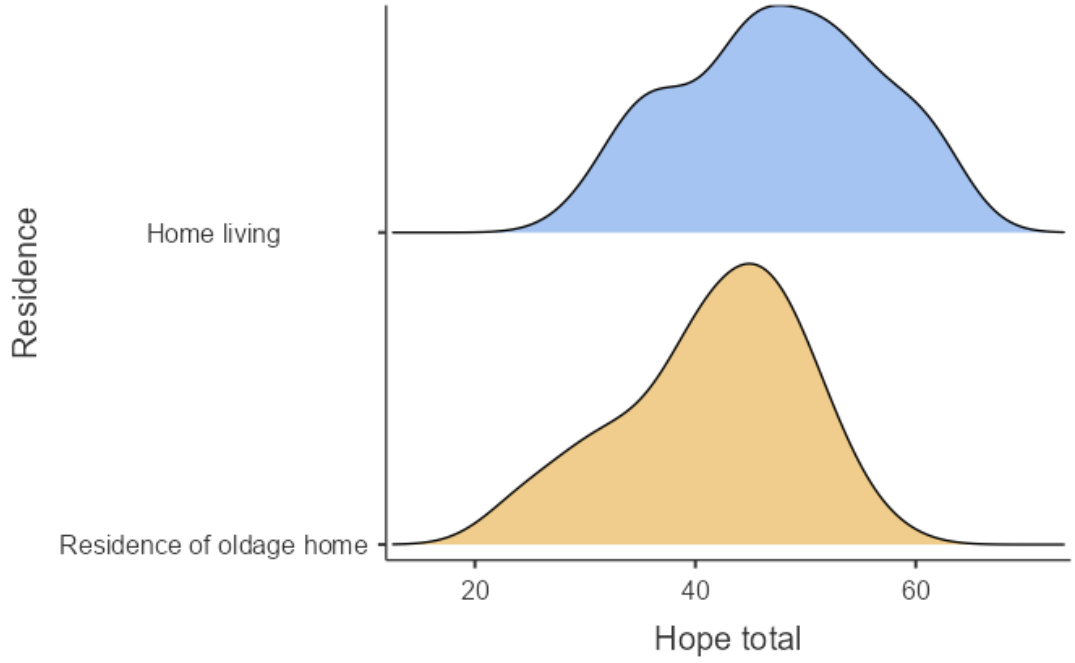


FIG-6: The graphical representation of the normality of the distribution (cognitive impairments)

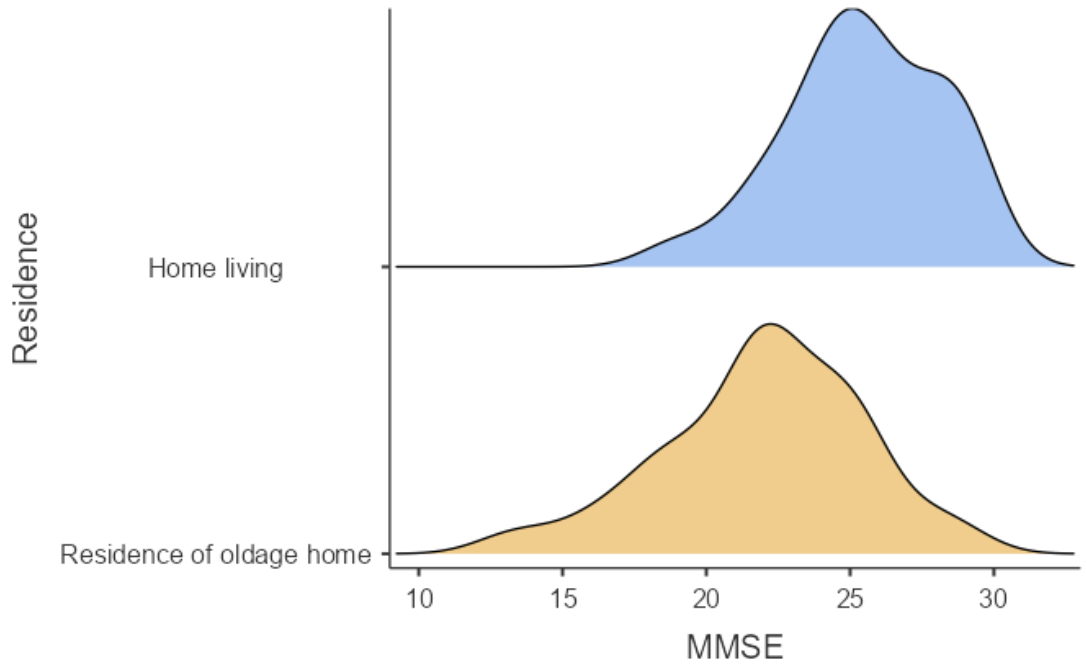


TABLE NO.2: RESULTS ON DESCRIPTIVE STATISTICS.

	Residence	**Depression**	**Quality of life**	**Hope-agency**	**Hope-pathway**	**Total Hope**	**Cognitive Impairment**
N	Home living	50	50	50	50	50	50
	Residence of an old-age home	50	50	50	50	50	50
Mean	Home living	5.46	85.6	22.6	24.5	47.5	25.5
	Residence of an old-age home	7.46	83.1	22.0	21.4	41.5	22.0
Median	Home living	5.00	88.5	22.0	25.0	47.5	25.0
	Residence of an old-age home	7.50	82.5	21.0	21.0	42.5	22.0
Mode	Home living	3.00	73.0	24.0	18.0	45.0	25.0
	Residence of an old-age home	6.00	76.0	23.0	24.0	45.0	22.0
Standard deviation	Home living	3.79	12.6	5.10	4.70	8.82	2.64
	Residence of an old-age home	2.17	9.75	4.97	4.15	8.11	3.47

Table No. 2 represents the mean and standard deviation of the variables (depression, quality of life, hope, and cognitive impairment)

Graphical Representation of the mean of depression, Quality-of-life, Hope, and Cognitive Impairments

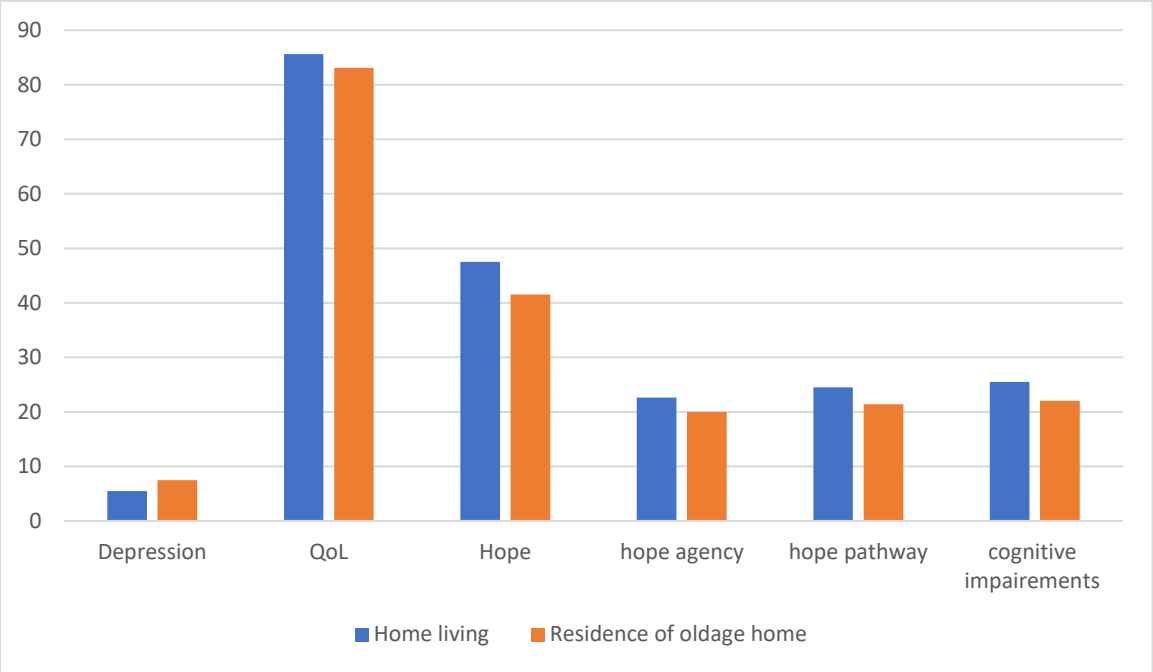


TABLE 3: RESULTS OF THE INDEPENDENT SAMPLE T-TEST

		Statistics	**Df**	**P**
Depression	Student's t	-3.24*	98.0	0.002
Quality of life	Student's t	1.13	98.0	0.263
Hope-agency	Student's t	2.62*	98.0	0.010
Hope-pathway	Student's t	3.56**	98.0	<0.001
Total hope	Student's t	3.54**	98.0	<0.001
Cognitive impairment	Student's t	5.67**	98.0	<0.001

*Significant at 0.05 level **Significant at 0.01 level

Table No. 3 represents that the variables – hope pathway, total hope, and cognitive impairments are significant at the 0.01 level, and depression and hope agency are significant at the 0.05 level. The variable- quality of life (QOL) is not significant at the 0.05 level. Hence, H2 is rejected for quality of life at the 0.05 level, and there is no significant mean difference between the two groups – home living and residence at an old age home in terms of Quality of life. H4, H5, and H6 are accepted at the 0.01 level, and H1 and H3 are accepted at the 0.05 level.

Chapter 5

DISCUSSION

DISCUSSION ON NORMALITY OF THE DISTRIBUTION:

The results of the normality of the distribution indicate that the Shapiro-Wilk P value is not significant. The sample is normally distributed.

In this research, the data showed a normal distribution across all variables, meaning their responses followed a consistent and balanced pattern. This is likely because people in old-age homes often have similar living conditions, routines, physical activity, access to healthcare, and emotional support, which leads to more uniform psychological and cognitive outcomes. On the other hand, data from home-living older adults showed that depression, hope-pathway, and cognitive impairment did not follow a normal distribution. These results suggest that home-living individuals experience more variation in their daily lives. Some may have strong family and social support, while others may be isolated or receive little care. Differences in health, nutrition, routine, and emotional well-being may cause some to remain stable while others experience more severe issues like depression or cognitive decline. This normality of distribution may be attributed to several possible factors, like -Adequate sample size, the selected groups may share similar demographic and psychosocial characteristics, leading to consistent data patterns (population homogeneity) and standardized and reliable instruments used for assessing depression, hope, cognitive function, and quality of life may have contributed to uniform data spread.

In the research, it is evident that depression is higher among the people residing in old age homes than individuals who are home living, and the quality of life is higher in both groups, and also hope is higher in both groups, i.e., home living and residence at old age homes. In the study titled “Depression and quality of life among the elderly: Comparative cross-sectional study between elderly in community and old age homes in Eastern India,” The elderly in old age homes were totally dependent on the old age home trusts, and the community elderly were from poor urban socio-economic status. The quality of life of the elderly in old age homes was slightly higher than that of the community elderly study population. This may be due to the reason that old age homes were providing the basic needs and facilities to the elderly, from which most of the middle and low socioeconomic community elderly were deprived. Other reasons for an improved quality of life may be better accessible medical care for physical illnesses and improved peer interaction with other inmates (Sahoo, S. et al., 2022). A study from Lucknow titled “Study of Depression in Geriatric Population: Old Age Home and Community in Lucknow, India” had found a higher prevalence of depression among the

geriatric population residing in old age homes as compared to the community (Mohan et al. in 2015). A study suggests that individuals with depression may exhibit lower levels of hope than individuals without depression (Chimich et al., 2004).

DISCUSSION ON DESCRIPTIVE STATISTICS:

This indicates the mean and standard deviation of the variables- depression, Quality of life, hope, and cognitive impairment.

In this research study, it is evident that the older adults in old-age homes reported higher levels of depression (M = 7.46, SD = 2.17) compared to those living at home (M = 5.46, SD = 3.79). These findings are consistent with prior studies indicating that institutionalized elderly individuals tend to experience more depressive symptoms due to factors such as social isolation, loss of independence, and reduced familial contact. According to Mohan et al. 2015, there is a significant mean difference between the elderly individuals living in the home and the residential home, where it was found that depression was more prevalent among the elderly individuals residing in old-age homes. According to Karini et al., 2019, it was evident that depression was significantly more prevalent in the case of elderly individuals living in an old age home than home-living individuals, and the findings revealed a significantly higher prevalence of depression among old age home residents (80%) compared to community-dwelling elders (52%) (p=0.003). A study by Bant et al (2020) reveals that the elderly at old-age residences are more prone to depression than home-living elderly individuals. This can be due to a lack of family support and age. A study by Mahat et al., 2021, indicates that depression is more common in the case of induvial living in an old-age home due to stress, family support, or low pension.

The quality-of-life scores were slightly higher in the home-living group (M = 85.6, SD = 12.6) compared to those in old-age homes (M = 83.1, SD = 9.75). Though the difference is modest, it reinforces the idea that older adults often maintain a better sense of autonomy, emotional support, and life satisfaction when living in familiar home environments. In support of this research, a study by Vignesh et al. 2022 indicates that there is no significant difference in quality of life between the two groups- elderly living in homes and elderly living in old-age homes. A study conducted by Rayirala et al. 2016 indicates the mean difference of quality of life between the two groups.

In the research study, the home-living group demonstrated higher mean scores in both agency (M = 22.6) and pathway thinking (M = 24.5), culminating in a total hope score of 47.5. In contrast, the old-age home group had lower scores across both dimensions (agency: M = 22.0, pathway: M = 21.4, total hope: 41.5). This suggests that older adults living at home feel more motivated and capable of generating strategies to achieve their goals. perceived family support significantly boosts optimism and goal-setting behaviour in elderly individuals. Research by Karn et al. (1996) indicates that hope is higher among elderly individuals in community-dwelling settings than in institutionalized settings. Another research conducted by Ron et al. (2004) indicates that elderly individuals living in a residential home exhibit higher hopelessness than elderly individuals living in their own homes. A study by Pandey et al. (2021 indicated that elderly living in their own homes exhibit a higher level of hope due to greater physiological well-being, a strong sense of purpose, life satisfaction, and positive emotions.

Cognitive impairment was lower in the home-living group (M = 25.5, SD = 2.64) compared to those in old-age homes (M = 22.0, SD = 3.47). This can reflect the protective role of sustained social interactions, cognitive stimulation, and familiarity with one's environment in maintaining cognitive functioning. There is similar research by Gautam et al. (2016) that indicates that cognitive impairments are more prevalent among older individuals who are living at old-age residences than those who are home-living. Another study by Lopes et al. (2021. indicates that cognitive and functional decline is more common in the case of the elderly in the old age homes. The study by Saruthan et al. (2022) indicates that old age residences elderly individuals are more likely to develop cognitive impairments. This can be due to as the elders in old age residences are more likely to lack a spouse or children, they are more prone to functional and cognitive decline.

DISCUSSION ON COMPARISON BETWEEN HOME-LIVING INDIVIDUALS AND RESIDENTS OF AN OLD AGE HOME.

The variables – hope pathway, total hope, and cognitive impairments are significant at the 0.01 level, and depression and hope agency are significant at the 0.05 level. The variable- quality of life (QOL) is not significant at the 0.05 level. Hence, H2 is rejected for quality of life at the 0.05 level, and there is no significant mean difference between the two groups – home living and residence at an old age home in terms of Quality of life. H4, H5, and H6 are accepted at the 0.01 level, and H1 and H3 are accepted at the 0.05 level.

The level of depression is significantly higher in the elderly residing in old age residences than in home living individuals, which came to be significant at the 0.05 level. This is probably because of social isolation and, lack of autonomy in old age residences. The level of hope and cognitive impairments is also found to be higher in the case of home-living elderly individuals. This can be due to a greater sense of autonomy, ongoing family interaction and social encouragement, familiar, non-restrictive environments, and informal daily conversations and decision-making opportunities at home stimulate cognition for the home-living individuals. But the results on quality of life are not significant ($p>0.05$). This may be due to as both of the groups receive basic care and safety

According to some past research, it is evident that depression, hope, and cognitive impairment are commonly more prevalent in the case of individuals living in old age residences. A study by Mohan et al. (2015) compared depression among old age homes elderly individuals and home-living individuals. The descriptive statistics were conducted, and it was evident that the variable depression is significant and is more prevalent in the case of the elderly residing in old-age homes. According to a study by Mahat et al. (2018), findings revealed that severe depression was significantly more common among those in old age homes, who were four times more likely to experience it than those living with family. A study conducted by Karini et al. (2019) indicated a significantly higher prevalence of depression among old age homes residents (80%) compared to community-dwelling elders (52%) (p 0.003). These results underline the need for routine mental health screening and support services for the elderly, particularly those in institutional settings.

A study by Vignesh et al. (2022) compared the elderly of old age homes and home-living, which revealed that there is no significant difference in quality of life between the two groups, although those in old age homes had slightly higher scores in psychological, social, and environmental domains. A study conducted by Rayirala et al. (2016) revealed that higher quality of life was linked to being well-educated, retired, in the middle socioeconomic class, free of unhealthy habits, and having a retired spouse in the “young old” age group. While quality of life appeared slightly better among old age home residents, the difference was not statistically significant.

A study by Karn et al. (1996) was conducted among community-dwelling older adults, where the findings revealed that there is high hope in community-dwelling individuals compared to institutionalized settings. However, no significant relationship was found between hope and

variables such as age, years retired, or income. A study by Pandey et al. (2021) revealed that elderly individuals living at home reported significantly higher levels of hope than those in old age homes. Higher hope was also linked to greater psychological well-being, including a stronger sense of purpose, life satisfaction, and positive emotions.

In support of this research, there is a study conducted by Saritha et al. (2022) which revealed that cognitive impairment is significantly higher in the case of elderly individuals who are home-living compared to elderly residing in old-age homes. Another study by Lopes et al. (2021) revealed that the cognitive impairment score is significantly higher in the case of residential old-age homes due to a lack of family interaction, high chances of depression, monotonous schedule, and environment.

Therefore, the data suggest that home-living older adults tend to fare better in psychological well-being (lower depression, higher hope), cognitive function, and quality of life than those residing in old-age homes. These findings underscore the importance of family involvement, environmental familiarity, and emotional support in promoting healthy aging.

chapter 6

CONCLUDING REMARKS

CONCLUSION:

The present study is undertaken to explore the differences between home-living elderly individuals and residents of old-age homes with respect to their mental health status (Depression, cognitive impairment, quality of life, and hope). The study was conducted on 100 participants, 50 of whom belong to home-living elderly individuals, and the other 50 participants belong to the residences of old-age homes, drawn from Kolkata and the surrounding area. The analysis of results is stated and discussed in the previous chapter of this report, and the major trend of findings obtained therefore seems to converge on certain factors on which the following conclusion may be drawn.

1. There exists a significant difference between home-living elderly individuals and residents of an old-age home with respect to depression. The depression has been found to be higher among residents of an old age home than home-living elderly individuals.
2. There exists no significant difference between home-living elderly individuals and residents of an old-age home with respect to quality of life.
3. There exists a significant difference between home-living elderly individuals and residents of an old-age home with respect to hope. The level of hope has been found to be higher among home-living elderly individuals.
4. There exists a significant difference between home-living elderly individuals and residents of an old age home in respect to agency thinking (hope), i.e., belief in one's ability to initiate and sustain actions towards goals.
5. There exists a significant difference between home-living elderly individuals and residents of an old-age home in respect to pathway thinking (hope), i.e., one's perceived ability to generate the path to reach or achieve the goal.
6. There exists a significant difference between home-living individuals and residents of an old-age home with respect to cognitive impairments. The cognitive impairments have been found to be higher among the residents of an old-age home.

LIMITATIONS OF THE STUDY

It is common that there is no end to research work because every end leads to a new direction, a new beginning. Basically, the limitations of the study come from the design, methodology, and how the data were collected, which influenced the application and interpretation of the work. The following aspects may be regarded as the limitations of the study:

1. Data were collected by using a self-administered questionnaire. So, the chance of biasness could not be controlled.
2. Due to time constraints, a compromise had to be made in case of sample size.
3. A personal interview should be conducted with each participant to better understand the individual differences.
4. Data were collected the participants who belong to various educational backgrounds, so the effect of different educational backgrounds could not be controlled.
5. Data were collected from the participants of different job profiles, so the effect of different types of jobs could not be controlled.
6. The presence or absence of the spouse of the elderly individuals of both groups could not be controlled.

IMPLICATIONS OF THE STUDY

The study area in which the investigation has been conducted has its important because the group consists of the Indian elderly population who are above 60 years. The purpose of the study is to assess the difference between home-living elderly individuals and residents of an old-age home with respect to their mental health status, depression, cognitive impairments, quality of life, and hope. So, from the result, it is seen that the residents of an old-age home face depression, cognitive impairments, and hope more compared to home-living elderly individuals. Though several factors are responsible for this, lack of family support and interaction, monotonous schedule at old age homes, pension, relationship with children and spouse, and many more. After investigating all the aspects, it can be said that residents of an old age home need to be valued, should have a sense of purpose, need to be appreciated, have strong emotional support, physical exercise, and community interactions. Some motivational programmes are needed to include the residents of the old-age home in some activities other than their routine schedule to reduce their monotonous life and enhance their self-esteem. Besides that, there is a need to improve the mental health status

of elderly individuals by awareness programmes, early diagnosis, treatment, and regular mental health check-ups.

SUGGESTIONS FOR FURTHER RESEARCH:

Due to time constraints and other difficulties, the study area of the present investigation could not be extended. In today's World, the aspect of the present study comparing mental health status among the elderly individuals who are living in homes and residences of an old age home creates a huge impact on the elderly population. So, there is enough opportunity for further research. Further research may be taken up in the following areas:

1. A sample can be drawn from different areas of West Bengal to get a clearer view of the mental health status of the elderly population.
2. Qualitative methods and quantitative methods both can be used to enhance the quality of work.
3. The impact of children on the mental status of the elderly population can be investigated.
4. The impact of the presence of a spouse on the mental health of the elderly population can be investigated.
5. Consequences of marriage and how marital satisfaction impacts on elderly population can be investigated.
6. The impact of educational qualification can be investigated.
7. The impact of the different types of jobs and income on the well-being of the elderly individuals can be investigated.
8. Monotonous life and the effect of retirement, which create more impact on the mental status, can be compared.
9. The influence of family type can be studied.

Chapter 6

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Chapter 7

APPENDICES

APPENDIX -A

CONSENT FORM

I, _____, age _____, residing at _____, give my consent to Ms. Rupsa Ray Chaudhuri to use the details and fill the questionnaire which is needed for her research purpose. I was fully informed about the procedure and I also have been informed about that all the information and the data gathered will fully be used for research purposes. I also understand my details and information will be kept confidential, and she will maintain my anonymity with regard to my response to the questionnaire items.

I hereby give my consent in the form of my signature below.

Signature of the participant _____

Date _____

APPENDIX- B

SOCIO-DEMOGRAPHIC DETAILS

Name (Initials):

Sex: male/ female/ other

Age:

Address:

Mother tongue:

Education:

Religion:

Residence: urban/suburban/rural residence

Family type & size:

Family income:

Marital status:

Occupation:

Working or retired:

Spouse: living / dead

Spouse age:

Relationship with the spouse:

How many children you have?

Do you live with your children?

Are you currently under any type of medication for any physiological or psychological illness: yes / no

If yes, kindly mention the name of the medication:

Do you have any history of physical illness: yes / no

Do you have any history of psychological illness: yes / no

signature of participant: _____

Signature of the researcher: _____ date: _____

APPENDIX- C

Instructions:

Circle the answer that best describes how you felt over the past week.

1. Are you basically satisfied with your life? YES / NO

2. Have you dropped many of your activities and interests? YES / NO

3. Do you feel that your life is empty? YES / NO

4. Do you often get bored? YES / NO

5. Are you in good spirits most of the time? YES / NO

6. Are you afraid that something bad is going to happen to you? YES / NO

7. Do you feel happy most of the time? YES / NO

8. Do you often feel helpless? YES / NO

9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO

10. Do you feel you have more problems with memory than most? YES / NO

11. Do you think it is wonderful to be alive now? YES / NO

12. Do you feel pretty worthless the way you are now? YES / NO

13. Do you feel full of energy? YES / NO

14. Do you feel that your situation is hopeless? YES / NO

15. Do you think that most people are better off than you are? YES / NO

APPENDIX- D

Instructions:

Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship.

Delighted- 7

Pleased- 6

Mostly satisfied- 5

Mixed- 4

Mostly dissatisfied- 3

Unhappy- 2

Terrible- 1

	Delighted	pleased	mostly Satisfied	mixed	mostly dissatisfied	unhappy	terrible
1. Material comforts home, food, conveniences, financial security	7	6	5	4	3	2	1
2. Health - being physically fit and vigorous . . .	7	6	5	4	3	2	1
3. Relationships with parents, siblings & other relatives- communicating, visiting, helping . . .	7	6	5	4	3	2	1
4. Having and rearing children	7	6	5	4	3	2	1
5. Close relationships with spouse or significant other	7	6	5	4	3	2	1
6. Close friends	7	6	5	4	3	2	1
7. Helping and encouraging others, volunteering, giving advice	7	6	5	4	3	2	1
8. Participating in organizations and public affairs	7	6	5	4	3	2	1
9. Learning- attending school, improving							

understanding, getting additional knowledge. 7 6 5 4 3 2 1

10. Understanding yourself - knowing your assets and limitations - knowing what life is about . . 7 6 5 4 3 2 1

11. Work - job or in home 7 6 5 4 3 2 1

12. Expressing yourself creatively 7 6 5 4 3 2 1

13. Socializing - meeting other people, doing things, parties, etc 7 6 5 4 3 2 1

14. Reading, listening to music, or observing entertainment 7 6 5 4 3 2 1

15. Participating in active recreation 7 6 5 4 3 2 1

16. Independence, doing for yourself 7 6 5 4 3 2 1

APPENDIX-E

Read each item carefully. Using the scale shown below, please select the number that best describes you and put that number in the blank provided.

1. = Definitely False
2. = Mostly False
3. = Somewhat False
4. = Slightly False
5. = Slightly True
6. = Somewhat True
7. = Mostly True
8. = Definitely True

1. I can think of many ways to get out of a jam.
2. I energetically pursue my goals.
3. I feel tired most of the time.
4. There are lots of ways around any problem.
5. I am easily downed in an argument.
6. I can think of many ways to get the things in life that are important to me.
7. I worry about my health.
8. Even when others get discouraged, I know I can find a way to solve the problem.
9. My past experiences have prepared me well for my future.
10. I've been pretty successful in life.
11. I usually find myself worrying about something.
12. I meet the goals that I set for myself.